THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 18 JUNE 2020
at 1.15 PM

Meeting held by teleconference

A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 23 April 2020	For Approval	TSH(M)20/03
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 20/25
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
7a	**Resilience Reporting - Covid 19 Response** Report by the Chief Executive	For Decision	Paper No. 20/26
7b	**Financial Update - Covid19** Report by the Finance & Performance Management Director	For Noting	Paper No. 20/27
	CLINICAL GOVERNANCE		
8.	**Clinical Governance Committee Annual Report 2019/20** Report by the Committee Chair	For Decision	Paper No. 20/28
9.	**Skye Centre 12 Monthly Report** Report by the Director of Nursing and AHPs	For Noting	Paper No. 20/29
10.	**Quality Assurance and Improvement** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 20/30
11.	**Clinical Governance Committee** Approved minutes of meeting held 13 February 2020	For Noting	CGC(M) 20/01
	STAFF GOVERNANCE		

12.	**Staff Governance Committee Annual Report 2019/20** Report by the Committee Chair	For Decision	Paper No. 20/31
13.	**Remuneration Committee Annual Report 2019/20** Report by the Chair	For Decision	Paper No. 20/32
14.	**Staff Governance Committee** Approved minutes of meeting held 20 February 2020	For Noting	SGC(M) 20/01

CORPORATE GOVERNANCE

15.	**Audit Committee Annual Report 2019/20** Report by the Committee Chair	For Decision	Paper No. 20/33
16.	**Annual Accounts for year ended 31 March 2020** Report by the Finance & Performance Management Director	For Decision	Paper No. 20/34 **To Follow**
17.	**Annual Review of Standing Documentation** Report by the Finance & Performance Management Director/Board Secretary	For Decision	Paper No. 20/35
18.	**Project Oversight Board - Update** Report by the Director of Security, Estates and Facilities	For Decision	Paper No. 20/36
19.	**Finance Report to 31 May 2020** Report by the Finance & Performance Management Director	For Noting	Paper No. 20/37
20.	**Performance – Annual Report 2019/20** Report by the Finance & Performance Management Director	For Noting	Paper No. 20/38
21.	**Property and Asset Management Strategy** Report by the Director of Security, Estates and Facilities	For Noting	Paper No. 20/39
22.	**Audit Committee** Draft minutes of meeting held 26 March 2020 (for approval at Audit Committee on 18 June 2020)	For Noting	AC(M)20/02
23.	**Corporate Risk Register** Report by the Finance & Performance Management Director	For Discussion	Paper No. 20/40
24.	**Any Other Business**		
25.	**Date of next meeting** 27 August 2020		

26. EXCLUSION OF PUBLIC AND PRESS

To consider whether to approve a motion to exclude the Public and press during consideration of the items listed as Part II of the Agenda in view of the confidential nature of the business to be transacted.

THE STATE HOSPITALS BOARD FOR SCOTLAND TSH (M) 20/03

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 23 April 2020, By way of teleconference.

Chair: Terry Currie

Present:

Non-Executive Director	Bill Brackenridge
Employee Director	Tom Hair {from Item 5}
Chief Executive	Gary Jenkins
Non-Executive Director	Nicholas Johnston
Non-Executive Director	David McConnell
Director of Finance and Performance Management	Robin McNaught
Non-Executive Director	Brian Moore
Director of Nursing and AHPs	Mark Richards
Medical Director	Lindsay Thomson

In attendance:

Chair of Clinical Forum	Aileen Burnett
Interim HR Director	Sandra Dunlop
Head of Communications	Caroline McCarron
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith
Director of Security, Estates and Facilities	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Currie welcomed everyone to the meeting, and no apologies were noted. He acknowledged that today's meeting was being conducted by way of teleconference and provided guidance for members in this regard.

2 CONFLICTS OF INTEREST

There were no declarations of conflicts of interests from Members in respect of the business to be discussed at this meeting.

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 27 February 20 were noted to be an accurate record of the meeting,

The Board:

1. Approved the minute of the meeting held on 27 February 2020.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted progress on the action points from the last meeting, with actions being progressed satisfactorily within the context of the current response to COVID-19. It was noted that progress in respect to some actions had not been possible for this reason and these actions would be carried forward for update at the next Board meeting.

The Board:

1. Noted the updated action list.
2. Noted that outstanding actions would be carried forward for update.

5 CHAIR'S REPORT

Mr Currie provided an update from two meetings of NHS Chairs' Group, which had taken place since the date of the last Board Meeting.

On 23 March 2020, the Chairs Group met with the Minister of Mental Health, and the meeting was focussed on issues relating to COVID-19. Mr Currie highlighted that at this meeting the Minister had expressed gratitude to all NHS Boards for producing local mobilisation plans in respect of the COVID-19 pandemic so expeditiously. It was noted that Board Secretaries would gather the various approaches to the maintenance of effective governance during this period. Boards would have sight of this.

The Minister had also noted the work progressed by NHS Boards in relation to recruitment of staff returning from recent retirement and of students, as well as redeployment of staff across the system.

The Minister advised that that 200k vulnerable people in Scotland would be notified by Friday 27 March, with regard to specific shielding arrangements. The public were being directed to contact NHS Inform rather than NHS24, for individualised advice

Mr Malcolm Wright, as Director General and Chief Executive of NHS Scotland, assured Chairs that clear direction would continue from Scottish Government. He also stated that visible leadership was critical and there would be an expectation on Chairs to demonstrate leadership through within their Board areas.

Mr Wright highlighted that it was essential to support staff locally, should they have queries around supplies of PPE and other support mechanisms so that these issues could be quickly addressed at a local level.

Chairs Group highlighted the following as priorities for resolution: availability of ventilators, availability of PPE, clarification on testing and with respect to key worker status.

An NHS Chairs only meeting took place on 20 April 2020, and the group received a presentation from Professor Carol Tannahill, Chief Social Policy Advisor to Scottish Government on the key areas of focus for Scottish Government over the course of the next few weeks; highlighting the role of testing and tracing in the suppression of the virus. Strategic planning would centre on "Respond, Recover, Renew" and each could run concurrently. Board Chairs were advised that Scotland was in the respond phase with focus on saving lives. The recovery phase would deal with the longer term control of infection through testing, tracing and vaccinating. The renew phase would focus on population health outcomes. Mr Currie noted that the First Minister would be speaking publically today on these themes.

The scale and pace of change in a short time was also highlighted in Professor Tannahill's

presentation, and the need for NHS Scotland to learn from this experience for the future. She described the potential harms to our society due to the impact of COVID-19: harm to health from the virus itself, wider health harms across the population due to necessary response mechanisms, and social harms.

Mr Currie asked the Board to note that Audit Scotland had asked external auditors for each NHS Board to review the temporary governance arrangements in place for appropriateness.

Mr Currie also asked Board Members to note that Scottish Government had confirmed a pausing of public appointments activity during the current crisis, with approval for this from the Commissioner for Ethics and Standards in Public Life. Any terms of office which ended within the next six months could be extended for up to nine months and there was also provision for appointment of experts for a short period. Mr Currie noted that this would not have an impact on The State Hospitals Board for Scotland (TSH) but that he had written to the Public Appointments Office to feedback the overall position for the Board over the course of the next 12 months.

The Board:

1. Noted this update.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins asked Board Members to note that his update would be focussed on the TSH response to COVID-19. He confirmed that he was participating in the weekly meetings for NHS Chief Executives. Key areas of focus for the NHS Chief Executive Group had included: the quadrupling of ventilated care capacity across NHS Scotland, intelligence for modelling, the testing approach, resourcing of the NHS Louise Jordan, the global challenge in relation to PPE, financial governance, and the provision of care within care homes.

The Board:

1. Noted the update from the Chief Executive

7 MAIN ITEM: RESILIENCE REPORTING – COVID 19 RESPONSE

A paper was received from the Chief Executive, to provide the Board with the background and framework through which TSH was managing its response to COVID-19.

Mr Jenkins led the Board through a detailed overview of the paper, noting the recent review of corporate governance arrangements for the Board agreed on 30 March and submitted to Scottish Government on 1 April. Ms Smith confirmed that should further feedback be received from Scottish Government, this would be circulated to Board Members. Further that a comparative exercise was being undertaken by the Chair of the Board Secretary Group for the NHS Chairs Corporate Governance Steering Group, to collate responses from across NHS Boards. An update to the Board would follow in this regard.

Action – Ms Smith

In relation to the Incident Command Structure, Mr Jenkins provided assurance to Board Members on the effective way in which this structure was operating emphasising transparency and the inclusive nature of the structure with partnership representation at all levels.

In respect of national guidance, the Board was asked to note the fast-paced and wide-ranging nature of this and the robust arrangements put in place within TSH to ensure that this was distilled for application for the organisation and to feed this through the Incident Command Structure. This enabled guidance to be closely monitored and implemented as soon as possible, with a TSH

perspective. In particular, Mr Jenkins summarised the main components of the Coronavirus (Scotland) Act 2020 and confirmed that a further update on this as well as financial governance arrangements would be provided at Item 14 by the Finance and Performance Management Director.

Mr Jenkins provided an outline of the timeline for the key decisions taken to date since the formation of the Incident Command Structure on 16 March 2020 and the lockdown restrictions put in place by U.K and Scottish Governments on 23 March 2020.

This had led to the development of the Interim Clinical and Support Services Operational Policy which was implemented on 30 March 2020. Mr Richards then described the development of this model in more detail including the work progressed with medical colleagues to assess each patient individually. The model was being kept under continuous review, with adjustments made it possible to reduce the restrictions on patients especially in terms of access to fresh air and activity. He advised that he and Professor Thomson co-chaired a weekly meeting to formally review the model, and decision-making was based on the daily flow of data supported through Clinical Effectiveness. The model was working well to date with no significant trends of concern, and the Mental Welfare Commission were being kept informed of developments.

Professor Thomson added that the overall aim of the model was to balance the physical protection of patients from COVID-19 and any risk to their mental health from isolation. She emphasised the work on individual care plans for patients and the detailed review of the model with adjustments made, allowed it to be sustainable for individual patients. In particular, 28 patients had been found to have co-morbidities and two required formal shielding, in line with national guidance. Mr Jenkins confirmed further measures had been put in place to support patients such as purchase of televisions as well as video visiting with carers.

The model had been in place for just over three weeks, and early indications was that it was effective in reducing the number of infections found at TSH, and this was placed within the wider populations spread of the virus.

In answer to a question on how the Board would be notified, should there be any significant incidents connected to implementation of the model, Professor Thomson confirmed that these would be reported to the Board directly. The number of patients who were unable to tolerate the model had been initially assessed at six and then revised to nine. It was agreed that a report would be devised for issue to non–executive directors as an indicator of the impacts on patients. Further detailed reporting would also be presented to the next meeting of the Clinical Governance Committee on 14 May 2020.

Action – Mr Richards/ Professor Thomson

The Board asked for further assurance on testing strategy within the hospital, and Mr Jenkins confirmed the position in line with national guidance and landscape. This position was being led nationally. The most effective tool at a local level was the infection control measures that had been implemented and then reviewed for compliance.

Mr Jenkins confirmed that clinical care guidance for COVID-19 patients had been developed with a six bed medical ward being established within the hospital, now equipped and ready to receive any patient who required enhanced care for COVID-19. Support for this had come from NHS Lanarkshire colleagues Each patient had also been assessed individually for what arrangements would be required to transfer them out of TSH for acute care, should this be necessary.

Within TSH, should any patient being cared for when approaching end of life, arrangements had been put in place for visiting for carers and specific infection control guidance had been developed to underpin this as a compassionate approach for patients and carers.

Mr Jenkins asked the Board to note that supply of Personal Protective Equipment for TSH was under daily review and that no significant concerns had been identified to date. Mr Walker linked into the national infrastructure for procurement as Single Point of Contact for the hospital. The Board asked

for assurance on this going forward and Mr Jenkins advised that a challenge in this area was not foreseen for TSH but that a national escalation framework was in place should any such challenge arise.

Mr Jenkins asked the Board to note the update on TSH attendance management data available formally to the end of February which demonstrated a continued improved position with a rolling absence figure of 5.75% over the past 12 months placing the organisation in a more positive place to respond to the current situation. He then updated Board Members on development of the Extreme Loss of Staff Plan taken forward through Gold Command which had identified the key processes and contingencies essential for the safe operation of the hospital. He underlined the particular challenge for TSH in requiring staff with specific skill set for care delivery; and advised on the work progressed in recruitment of student nurses as well as recently retired staff returning to work temporarily in order to help maintain a sustainable workforce.

Mr Jenkins asked the Board to note the measures put in place to support staff well-being, as well as the supportive mechanisms in place to help to encourage staff back to work should they have experience of illness or self-isolation due to COVID-19. It was noted that staff were taking part in testing as necessary either at Glasgow Airport or more locally through NHS Lanarkshire.

Good Communication was also highlighted as essential for staff and this was led through daily Staff Bulletins as well as through Bronze Commanders and line managers directly with staff across the site.

The response to COVID-19, had impacted on business continuity across the organisation in other areas. These were summarised within the paper and Board Members were asked to note that this had been reported to Scottish Government with further updates to be made as required. The Board would receive a further update on the security re-fresh project at Item 13, which would continue with a revised schedule of works.

The Board welcomed the very detailed nature of the report and verbal update from the Chief Executive, both of which were considered to be helpful.

A question was raised in regard to possible delays in transfer of patients being cared for at TSH under exceptional circumstance arrangements. Professor Thomson confirmed that no exceptional circumstance patient was past the date upon which they should have been transferred. Scottish Government were reviewing whether there was any need to make legislative change in this area. She advised that in general across the Forensic Network, referrals were continuing although at a decreased rate with some concern that individuals could be in a prison setting awaiting assessment – the Forensic Network had put in place a monitoring programme to keep this under review.

Mr Currie emphasised the need for continued good governance through careful recording of all decisions made throughout the organisational response. On behalf of the Board, he noted the comprehensive nature of reporting which was much appreciated, and that to date the Board was assured that the response within the organisation was being well-managed. It was noted that in the context of current national concern about availability of PPE, there were no significant local concerns for TSH.

<u>The Board:</u>

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

2. Endorsed the framework for operational management and governance.

3. Confirmed that there were no additional addition reporting requirements required, other than reporting on the impact of the interim clinical model on patients, which would be led by Professor Thomson and Mr Richards.

8 CLINICAL SERVICE DELIVERY MODEL IMPLEMETATION PLANNING – UPDATE

A paper was received from the Medical Director, which provided the Board with a detailed update on progress achieved on the implementation process for the new clinical service delivery model. At the meeting of the Clinical Model Oversight Board (CMOB) on 23 March 2020, a decision had been taken to pause the implementation phase, given the need to respond to the pandemic, Professor Thomson provided Board Members with assurance that the implementation of the new clinical service delivery model would be a priority once the immediate need to respond to the pandemic had been managed.

The CMOB was due to review this positon in June 2020 and a further update would be brought to the Board thereafter.

The Board:

1. Noted the progress achieved to date on implementation of the clinical service delivery model to March 2020, and the need to suspend this work to enable the response to the COVID-19 outbreak.
2. Noted that a further update would come to the Board, following the next meeting of the CMOB in June 2020.

9 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

A paper was received from the Medical Director and the Director of Nursing and AHPs which provided an update on the progress made towards quality assurance and improvement activities.

Ms Merson led members through the detail of the report, asking them to note that as part of the revised Board Workplan for 2020, this was the first report of this kind providing assurance on quality assurance and quality improvement in TSH. She outlined the five key areas of activity in quality assurance including clinical audit and outcomes, the work progressed in response to the Forensic Network Continuous Quality Improvement Framework, a summary of learning from complaints activity as well as the outcomes of two visits from the Metal Welfare Commission

Ms Merson highlighted quality improvement work within TSH as a significant area of development over the past 2 years with the formation of the Quality Forum as well as the TSH30-30 initiative. She asked the Board to note the process in place within the hospital for ensuring that all guidelines and standards published and received were checked for relevancy and evaluated if appropriate.

Ms Merson noted that COVID-19 was currently impacting the ability to deliver programmes of work, and this was a similar picture nationally. She was connecting with other QI leads through NES on the response to COVID-19 from a QI perspective and for any lessons that could be learned from this experience. In particular, Ms Merson described the recent activity on COVID-19 by Clinical Effectiveness which was enabling the marrying of clinical decision–making with available data evidence.

Board Members welcomed this report and noted the usefulness of its content with quality assurance and improvement a primary function of the organisation. Mr Currie noted the great strides in this area over the past 18 months and paid tribute to Ms Merson's leadership as well as the work of her team.

The Board:

1. Noted the content of the report.
2. Asked for reporting to continue to the Board in this format

10 NURSE AND AHP REVALIDATION – ANNUAL UPDATE

A report was received from the Director of Nursing and AHPs, which outlined the process within TSH for monitoring revalidation of nursing and AHP staff cohorts for the period 1 April 2019 to 31 March 2020.

Mr Richards provided a brief summary of the key points giving assurance to the Board that with the exception of two cases, all staff were revalidated appropriately throughout the course of the year.

The Board:

1. Noted the content of the report.

11 PATIENT LEARNING SERVICE 12 MONTHLY REPORT

The Board received a report from the Interim HR Director which provided an outline of Patient Learning Activity throughout January to December 2019. Ms Dunlop provided a high level summary of activity in this area including key achievements, current challenges and future developments.

Ms Dunlop highlighted the positive progress made in core skills development, open and distance learning as well as vocational training and ICT skill development, arts and crafts and personal and social development skills. She highlighted the positive trajectory of performance data for 2019, in comparison to the five previous years. Some key areas of good practice in flexible delivery and enhanced learning support, SQA Verification and success of patients, staff and volunteers at the Staff Excellence Awards in October 2019.

Board Members acknowledged the good work carried out in this area and that the positive nature of this report underlined this, producing excellent outcomes for patients with inspirational stories. The Board reflected on the warm feedback from an SQA External Verifier (included at appendix 2) which also demonstrated this.

The progress made on delivering learning in areas which had previously experienced challenge was noted such as gardening, small animal care, and crafts.

In answer to a question on volunteers within the learning programme, Ms Dunlop confirmed that there was no cap on the number of volunteers able to be involved but that the numbers did tend to be low. Any increase in these numbers would facilitate more one to one work with patients especially on literacy and numeracy skills. She also advised that work was progressing to reconsider the delivery of learning to patients during the COVID-19 response where one to one learning may be most practicable.

She also underlined that following the IT network upgrade within the Patient Learning Centre, there would be a roll out of the network to other areas within the Skye centre, and thereafter consideration could be given to extending this to ward areas.

Mr Currie summarized the discussion for the Board, noting this as an area of continued excellence within the hospital. He thanked Ms Dunlop for her report and asked that she pass on the Board's comments and appreciation of the team's work.

The Board:

1. Noted the content of the report.

12 WORKFORCE PLAN – UPDATE

A paper was received from the Interim Director of Human Resources, which provided an update to the Board on progress in respect of the Workforce Plan. The Board had agreed at their meeting in December 2019 that this work should be paused to allow review of the workforce with the implementation of the Clinical Service Delivery Model in spring 2020, as well as use of the common staffing method developed through workforce tools pending the enactment of the Health and Care Staffing legislation.

The Board was asked to note that In line with the pausing of the implementation of the new clinical model due to COVID-19, workforce planning had been suspended. Work would recommence as part of a staged process contingent on national and local activities associated with COVID-19. Further reporting would come to the Board in this respect.

The Board:

1. Noted the content of the report.

13 PROJECT OVERSIGHT BOARD – UPDATE AND GOVERNANCE ARRANGEMENTS

A report was received from the Director of Security, Estates and Facilities which summarised the current status of the Perimeter Security and Enhanced Internal Security Systems Project.

The successful contractor was Stanley Solutions Ltd (Stanley) and the finalised contract was signed in February 2020.

In accordance with Scottish Government guidance on continuation of work essential to public services, contract works were able to commence on 6 April 2020. A revised plan of works had been agreed, which ensured the pausing of works involving the decant of wards, during the COVID-19 response. Alternative works had been commenced in the interim with no significant time of costs delay to the contract works overall, and minimal impact on daily activities in the hospital. All works being conducted had been risk assessed as a safe system of work under COVID-19 precautions specifically.

Mr Jenkins noted that this updated position would be advised to Scottish Government, as it had originally been thought that works may have to be paused altogether.

Action – Ms Smith

The Board:

1. Noted the content of this report.

14 FINANCE REPORT AS AT 31 JANUARY 2020

The draft Finance Report to 31 March 2020 was submitted to the Board by the Finance and Performance Management Director, and Members were asked to note the content of this report. This report remained in draft pending audit.

Mr McNaught led Members through the report highlighting the key areas of focus notably that the Board was reporting an overall underspend position of £0.150m to 31 March 2020 which was a year to date favourable variance of 0.4%. The underspend positon was mainly due to the significant reduction in nursing overtime costs.

Mr McNaught provided an update on the additional costs incurred in the final month of the financial year regarded as being due to the COVID-19 response, as well as the financial governance arrangements in place to report these costs to Scottish Government. The new governance arrangements in place from April 2020, included specific reference to any costs in excess of

£100,000 requiring agreement by Scottish Government.

Work was progressing across all directorates to maintain accurate revenue budgeting, and with a strong emphasis on the management of savings, and a main aim of reducing the non-recurring element of savings.

Mr McNaught also updated the Board on a change to practice within information governance due to COVID-19 with the response time under FOISA being increased from 20 to 60 working days.

The Board welcomed the draft report which demonstrated an improved position in comparison to prior years. In particular the position on nursing overtime was noted as much improved and the Board extended their appreciation of this to Mr Richards and his team. This should provide a platform for reviewing spending throughout wider areas of the organisation going forward.

In answer to a question from Mr McConnell, on the further financial pressures experienced due to the COVID-19 response pushing the Board past its current indicative positon of £150k underspend, Mr McNaught provided assurance to the Board that he did not think that this was discernible risk.

Mr McNaught advised that national guidance was awaited on preparation and submission of the annual accounts – the 30 June 2020 deadline still applied but it may become allowable to extend this to 30 September 2020 should preparation and audit of accounts became too challenging during the response to COVID-19. An update from Scottish Government was expected during May 2020.

The Board:

1. Noted the content of this report.

15 AUDIT COMMITTEE

The Board received the approved minutes of the meeting of the Audit Committee which had taken place on 23 January 2020. As Chair of the Audit Committee, Mr McConnell asked members to note that a verbal update for this meeting had been provided at the last Board Meeting in February 2020.

The Board:

1. Noted the approved minutes of the Audit committee on the meeting held on held on 23 January 2020.

16 CORPORATE RISK REGISTER

The Board received a paper from the Finance and Performance Management Director, which provided an overview of the medium, high and very high risks featuring on the Corporate Risk Register, and to provide assurance that these were being addressed appropriately.

Mr McNaught provided a summary of the report for the Board, noting the important addition of COVID-19. Ms Merson provided a further update to confirm that work was being progressed to ensure that the impact of the response to COVID-19 was considered in relation to existing risks on the register. Mr Jenkins confirmed that this was reviewed weekly within Gold Command, as part of the incident command resilience response.

The Board noted the report and did not consider that discussion at today's meeting had indicated that any amendment or addition should be made to the Corporate Risk Register

The Board:

1. Noted the content of this report

17 ANY OTHER BUSINESS

Mr Jenkins advised the Board that he had received feedback correspondence from Scottish Government in relation to the draft Annual Operational Plan for The State Hospital for 2020/21, however, agreement on the plan had been paused due to the COVID-19 situation. This position would be re-visited with NHS Boards as soon as possible. Mr Jenkins would circulate a copy of the letter to Board Members for their information.

Action – Ms Smith

On behalf of the Board, Mr Currie formally recognised and paid tribute to the exceptionally hard work carried out by staff over the last few weeks in response to COVID-19, and that the degree of control within the hospital clearly demonstrated the commitment by staff. The Board wished to thank all staff for their hard work and contribution to the COVID-19 response.

18 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 18 June 2020, with the arrangements for the meeting to be confirmed closer to that date.

ADOPTED BY THE BOARD

CHAIR 

(Signed Mr Terry Currie)

DATE 18 June 2020

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 2020	Clinical Service Delivery Model (item 7)	Update on key milestones for delivery – overall financial monitoring and recording on Corporate Risk Register.	R McNaught/ M Merson	April 2020 – paused	**Paused due to Covid-19**
2	February 2020	Annual Operational Plan (Item 16)	Reflect content of AOP in governance committee workplans	M Smith/ Committee Chairs/ Exec Leads	Ongoing	**Paused - Committee agendas are reviewed in context of Covid -19 response.**
3	February 2020	Security Project Update (Item 17)	Terms of reference to be approved by POB, and submitted to Board	D Walker	April 20	**Delayed due to Covid-19 <u>On Agenda June 2020</u>**
4	February 2020	Corporate Governance Improvement Plan (Item 21)	Review engagement plan for Board in holding meetings externally	G Jenkins/ M Smith/ C McCarron	Ongoing	**Paused due to Covid-19**
5	April 2020	Covid 19 Response (Item 7)	Update on Corporate Governance Steering Group overview of NHS Board governance arrangements	M Smith	June 2020	**<u>On Agenda June 2020</u> as part of Covid-19 update**

6	April 2020	Covid 19 Response (Item 7)	Update to Non- Exec Directors on monitoring of interim clinical model	L Thomson/ M Richards	Immediate	**Completed – agreed monthly reporting plus by exception if significant issues arise**
7	April 2020	Project Oversight Board (Item13)	Update to Scottish Government on status of project works during Covid-19	M Smith	Immediate	**Completed - Update reported and included in Interim Remobilisation Planning**
8	April 2020	Any Other Business – Annual Operational Plan Update	Copy of Scottish Government Feedback letter to Board Members	M Smith	Immediate	**Completed**

Paper No. 20/07

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2020
Agenda Reference:	Item No: 7
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary/ Head of Corporate Planning and Business Support
Title of Report:	The State Hospital Resilience Response to Covid 19 Global Pandemic
Purpose of Report:	For Discussion

1 SITUATION

The State Hospital has responded to the unprecedented global Covid-19 pandemic through the prioritisation of strategies to protect the health and wellbeing of patients and staff and to minimise, as far as possible, the risk of transmission of the virus through staff and patient populations.

The Board received a report at its meeting on 23 April 2020 to set out the governance structures and operational actions taken to meet the twin aims of health protection and prevention of spread.

2 BACKGROUND

This further report will provide the Board with a detailed updated on the framework through which TSH is managing its response to the Covid-19 outbreak.

2.1 Board Governance

In March 2020 all NHS Boards were asked to carry out a review of corporate governance. On 1 April 2020, The State Hospitals Board for Scotland (TSH) submitted reports to Scottish Government on its review of the corporate governance framework for the NHS Board to ensure effective oversight during the coming months. This review was conducted within the requirement of existing legislation, and in reference to the existing Standing Orders of the Board. It was agreed that this position should be reviewed by the Board within six months, or sooner should the global pandemic situation change significantly, and this positon is being kept under active review.

Scottish Government has asked the NHS Chairs Group to sponsor a comparative review of the positions taken across NHS Boards. This exercise has been commissioned through the Chair of the national Board Secretaries group, with a questionnaire devised to capture differing positions throughout. TSH submitted its response by the due date of 27 May 2020, and an update is now awaited on the result of the comparative analysis. This will be reported to the Board, taking a particular focus on any lessons learned for governance throughout this challenging period.

Since the date of the last Board meeting, there have been two governance committee meetings with the Audit Committee meeting on the morning of this Board meeting. The focus of agendas for

each meeting have been considered and adjusted appropriately to reflect the ongoing pandemic and the response required with specific reference to the remit of each committee.

In addition, the non-executive members of the Board have met with the Chair and Chief Executive, and have also received updates on the Interim Clinical and Support Services Operational Policy.

2.2 Incident Command Structure

At its meeting on 23 April 2020, the Board received detailed reporting on the establishment of an Incident Command Structure in accordance with the resilience framework of TSH to ensure that TSH, as part of NHS Scotland, has emergency preparedness in place to plan for and respond to a major incident. Within this framework there are three levels of planning and response, and the Covid-19 pandemic is a Level 2 event. This means that significant service disruption problems are expected which will require the special redeployment of staff or other resources with an associated interruption to the routine services of the hospital. Further, that these are likely to affect multiple departments/areas of the hospital and will require full plans.

Since its inception on 16 March 2020, the Incident Command Structure has been led by the Chief Executive Officer as Gold Command, supported by the Director of Security, Estates and Facilities and the Director of Nursing and AHPs as Silver Command. To support partnership working, the Employee Director and designated deputy is part of this structure as Bronze Command, and is a member of the Silver and Gold Commands. A formal log is kept of each meeting, through which decisions and actions are tracked and can be evidenced.

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 has been graded as a very high risk and as a result this risk is reviewed weekly at Gold Command.

On 29 April 2020, it was decided through Gold Command that Silver Command could reduce frequency of meetings to three times a week, with a newly constituted Hospital Huddle meeting on the other four days. This commenced on 4 May 2020. The Hospital Huddle has particular focus on the daily operational management of the hospital resourcing. Gold Command meetings are held at a minimum of once a week. Both Silver and Gold Command meetings can be stood up for additional meetings should there be any urgent matters of operational or strategic focus.

The Covid Support Team continues to support the Incident Command Structure, with dedicated advice from infection control, risk management, operational management and human resources.

2.3 National Guidance

National guidance has developed at pace to support adjustment and response of the NHS and wider public services in managing the global pandemic. Guidance has emerged from UK Government, Scottish Government and Professional Bodies with key areas of guidance and legislation providing the framework through which TSH has shaped the response to Covid-19. Guidance is tracked and reviewed through the Incident Command Structure on a daily basis and through the Scientific and Technical Advisory Group (STAG) weekly to ensure that TSH is operating in compliance with all relevant guidance. Gold Command receives assurance through the incident command structure.

2.3.1 TSH Scientific and Technical Advisory Group (STAG)

The TSH Scientific and Technical Advisory Group (STAG) was established in response to a letter from the interim Chief Medical Officer (CMO) on 7 April 2020, requiring each hospital in Scotland to

develop a team to gather and monitor epidemiological data to inform the response to the Covid-19 pandemic. The STAG meets weekly, met for the first time on the 21 April 2020, and is jointly chaired by the Medical Director and Director of Nursing and AHPs. The group membership also includes representatives from the Covid Support Team. Public Health and Infection Control advice is provided by Consultants in Public Health and Microbiology from NHS Lanarkshire. The STAG links into the wider Command structure in the hospital through the weekly provision of information and advice for consideration at Gold Command. The STAG also defines which information generated through the reviews and monitoring processes conducted, should be directly provided to staff through the dedicated Covid intranet resource.

The remit of the group includes:

- To collate and review TSH Surveillance and epidemiological data in comparison to geographical area and national data on the Covid-19 outbreak, and provide reports as required through the work of the State Hospital Enhanced Surveillance Group.
- To advise on local implementation of national guidance on the management and prevention of infection control
- To provide a coordinated approach to the provision of scientific and technical advice for the development and implementation of local pathways and protocols and recovery planning with particular regard to infection control, occupational health and public health.
- To provide oversight of reporting of healthcare infection data to Health Protection Scotland and Scottish Government, and to coordinate this with other reporting strands.
- To provide a forum for the discussion of emerging scientific and technical issues in particular in relation to infection control, occupational health, and public health aspects of the Covid-19 outbreak and the State Hospital response.
- To consider other matters as determined by Gold Command.

Over the initial six weeks of the STAGs operation it has closely monitored all patient and staff incidence of Covid-19, breaking the data down for further analysis. STAG has reviewed patient and staff testing numbers and processes with the aim of informing future test and trace protocols and recovery planning, and has monitored Covid-19 related staff absence. The extent of the Literature and Guidance that has been reviewed is considerable. A number of Covid-19 specific information resources have been provided for staff through the Covid-19 Intranet pages, and any data or advice with implications for the hospital's operation has been fed back to Gold Command for consideration in relation to the Interim Clinical and Support Services Operational Policy.

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.

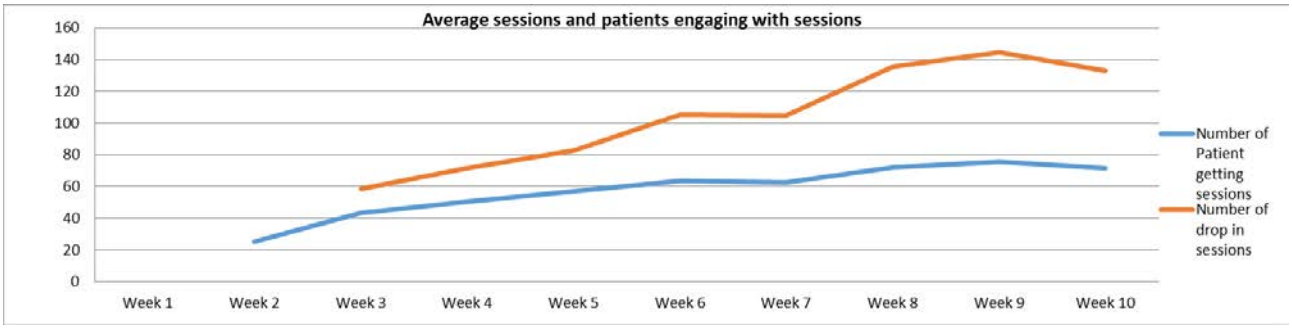
CLINICAL GOVERNANCE

3.1 Interim Clinical and Support Services Operational Policy

The Interim Clinical Operational Policy remains subject to regular scrutiny and review. This is underpinned by daily data gathering and reporting, and a formal weekly review meeting which results in a recommendation to Gold Command regarding continuation and/or adjustment to the Policy. Monitoring is focused on a range of key areas of data including clinical incidents, observation levels, patient feedback and participation in purposeful activity. The Mental Welfare Commission receive weekly reports, which adds an important additional element of scrutiny.

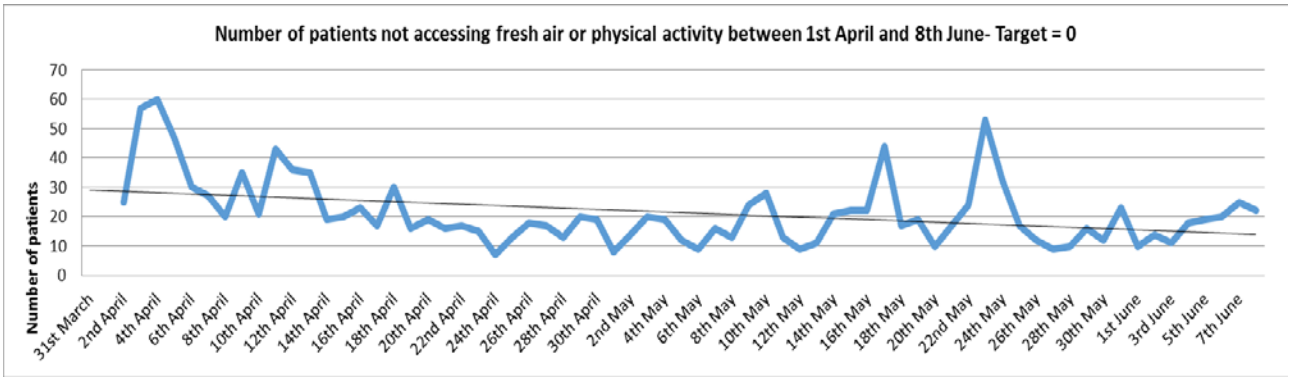
The Policy is now on its 9th version, and there has been a gradual increase in access to activity realised through changes that have been made. Examples of this include the re-opening of the Hub areas for activity, and full grounds access being re-instated. Participation in planned sessional activities is high. Feedback from clinical teams is largely positive, with our patient group engaging well with the changes to our model of care delivery. Graph 1 below illustrates the number of sessions offered and patient engagement with these. There are a small number of patients (n=9) who are unable to tolerate the model, and who are cared for in the main ward environment.

Graph 1- Average sessions and patients engaging with sessions



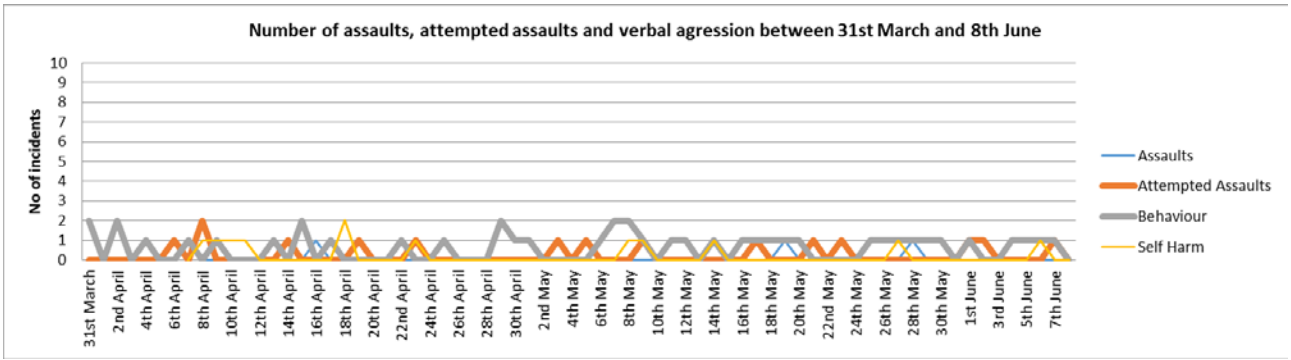
Monitoring of patients not accessing fresh air or physical activity over each week is carried out. Graph 2 below illustrates an overall downward trend in this with variation in weeks 7 and 8 due to patient acuity. In these weeks 1 and 3 patients respective did not access either fresh air or physical activity, one was in Covid isolation; one in SRKs and the other had been offered but declined There was only one patient that did not access fresh air or physical activity in week 10. The patient did however engage with timetable activities on 4 out of 7 days.

Graph 2 – Number of patients not accessing fresh air or physical activity 1st April – 8th June



Monitoring of the number of assaults, attempted assaults and verbal aggression is carried out. Graph 3 below illustrates random variation with these. The graph provides data from week 6 onwards, in this week there was an overall increase in the number of incidents. In total there were 2 attempted assaults, 7 behaviour and 2 self-harm incidents. Week 7 saw slightly less incidents with 1 assault, 1 attempted assault, 5 behaviour and 1 self-harm. One behaviour incident resulted in the Public Order Police being called. Week 8 saw one assault, 2 attempted assaults and 3 behaviour. In week 9 there was a rise from 6 to 10 incidents: 2 assaults (one on staff and one on peer), one attempted assault, 6 behaviour (hostile) and 1 self-harm. Week 10 saw a reduction to 8 incidents: 1 assault on staff; 2 attempted assaults on staff; 4 behaviour incidents and 1 self-harm incident.

Graph 3 Number of assaults, attempted assaults and verbal aggression between 31st March and 8th June



3.2 Infection Control

A strong focus on infection prevention and control has been central to the Board's response to Covid-19. The Senior Nurse for Infection Control is part of the internal Covid-19 response team with external support from Dr Tom Gillespie (Consultant Microbiologist/Infection Control Doctor in NHS Lanarkshire).

The State Hospital Pandemic Influenza Outbreak Plan, the Pandemic Influenza Communication Strategy and HAI Outbreak Reporting requirements have been reviewed against the incident command model. It has been confirmed that all areas of activity described in these plans are covered through our incident command arrangements**.**

Specifically, the Silver Command level has superseded the Infection Control Problem Assessment Group and Incident Management Team that is normally a requirement when managing an outbreak situation. This will be reviewed should there be further outbreaks of infection.

National guidance related to Covid-19 is being issued regularly and has also been subject to regular updates. To help ensure connectivity in this area the Senior Nurse for Infection Control is involved in the following teleconferences:

- Health Protection Scotland x 1 weekly
- The State Hospital staff side daily
- Silver Command briefings
- State Hospital Huddle
- Scientific Advisory & Technical Group (The State Hospital)

In addition the Senior Nurse for Infection Control continues to be a member of Lanarkshire Infection Control Committee and Lanarkshire Infection Prevention & Control Assurance Sub Group.

The following pieces of work have been put on hold to allow space for the necessary focus on Covid-19:

- Monthly Hand Hygiene audit reporting
- Monthly HAI Reporting Template
- Infection Control Annual Report and Clinical Governance Report.

The Infection Control Committee will re-start in July 2020.

The Executive Team are also connected to various national and regional meetings concerning managing and leading the response to Covid-19 as it relates to infection control.

It was agreed by the Senior Nurse for Infection Control, supported by the Infection Control Doctor that the national guidance for household isolation would be implemented as an initial framework for guiding our response to Covid-19. As more guidance has been produced by HPS / PHE a combination of the following documents were used to inform the State Hospital Clinical Care Guidance document:

- Infection prevention and control measures - caring for a variety of patients including some who may be suspected or confirmed cases of Covid-19
- Guidance for non-healthcare settings
- Information and guidance for social or community care and residential settings
- Guidance for first responders and others in close contact with symptomatic people with potential Covid-19

COVID-19 Incidents

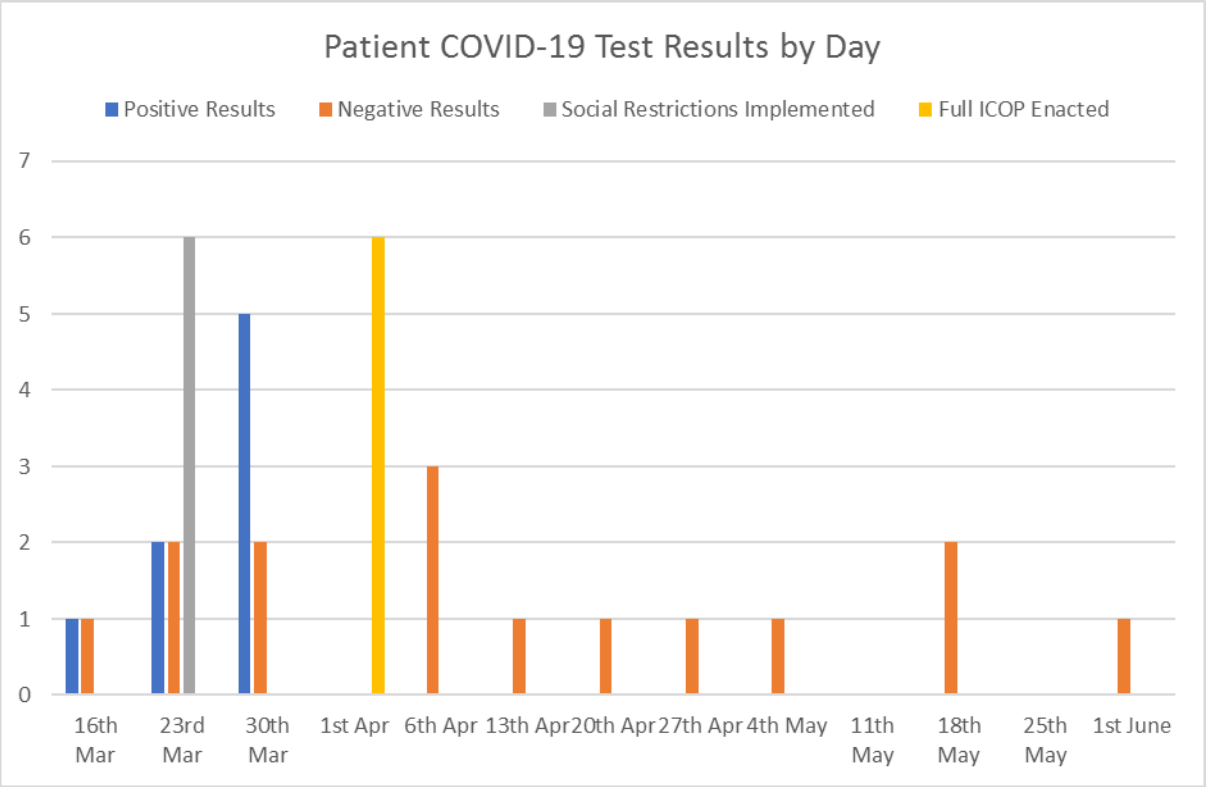
Since 17 March 2020, 25 patients have been tested with 8 positive cases confirmed all of whom have recovered without medical intervention.

Table 1: Number of Patient tests, positive and negative results by week with cumulative total.*

Week commencing	16th Mar	23rd Mar	30th Mar	6th Apr	13th Apr	20th Apr	27th Apr	4th May	11th May	18th May	25th May	1st June	Total
Total Tests	2	4	7	3	1	1	1	1	0	2	0	1	23
Asymptomatic tests	0	0	0	0	0	0	1	1	0	0	0	1	3
Positive results	1	2	5	0	0	0	0	0	0	0	0	0	8
Negative results	1	2	2	3	1	1	1	1	0	2	0	1	15

*Data refers to the date on which the Covid-19 Test was conducted

Figure 2: State Hospital Patient Covid-19 test results by day



3.3 Test and Protect

The approach of Test and Protect is being led through Gold Command and in alignment with the current national position. The expert advice of the STAG supported specific testing and tracing approaches developed to meet the unique needs of a high secure hospital.

Testing:

A two-tier approach to testing has been agreed for The State Hospital:

1) Testing will be undertaken on the grounds of symptomatic presentation, or if a member of staffs' immediate household is self-isolating. This applies to both patients and staff and will remain the default position until national guidance supersedes.

2) TSH will be viewed in a similar way as the 'priority 1 schedule' in the national testing model. This will enable enhanced testing for symptomatic and asymptomatic staff and patients in the event of an increase in Covid-19 positive cases within the high security estate. The definition of an increase in cases, and the associated testing intervals, is being defined further in conjunction with Public Health and Infection Control colleagues.

The initial agreed method for enhanced testing would be through the deployment of mobile testing units, available to NHS Scotland and supported by the armed forces. Discussion is active with NHS Lanarkshire colleagues around the use of NHS testing capacity. This would be preferable due to the result feedback process.

The Director of Security, Estates and Facilities is Single Point of Contact for Testing at TSH. As testing technology advances, alternative methods, such as home testing for staff, rapid diagnosis kits, and other mechanisms may be adopted to aid the testing process.

Tracing:

Agreement was reached between TSH and NHS Lanarkshire that tracing for staff would be undertaken by NHS Lanarkshire tracing resource. The tracing process is triggered by a laboratory confirmed positive case.

The tracing process for patients will be undertaken through the Covid-19 support team. The reason for an internal tracing process is twofold; external tracing teams will have limited ability to access patients within TSH, all patient movements are monitored and recorded by the internal hospital systems and CCTV. It is therefore more effective to undertake an analysis of patients contact within the organisation. The same method and process for tracing will be applied internally.

3.4 Clinical Care Guidance for COVID -19 patients

The Covid-19 TSH Clinical Care Support Documentation was developed to assist in the care of patients who have Covid-19 within The State Hospital**.** It has been developed in partnership with key individuals within The State Hospital and NHS Lanarkshire who will provide support to patients who require enhanced medical and nursing care for physical health symptoms as a result of Covid -19.

A six bed General Medical ward was established in Mull Hub which is equipped and ready to accept any patient who requires enhanced care for symptoms of Covid-19. Staff induction has been completed. To date, there has not been a requirement to use this ward.

The Medical Emergencies Policy and Procedure has been revised to include the donning and doffing of PPE and based on guidance issued by Health Protection Scotland.

3.5 Personal Protective Equipment

The State Hospital continues to be linked with National Services Scotland (NSS) through procurement. National stockpile supplies have been received by the hospital for Personal Protective Equipment (PPE). To date, there have been no issues with stock availability on site. Minor issues such as aprons and glove delays have been experienced along with other Boards however this has had no impact operationally. Escalation routes remain available through the TSH Single Point of Contact (SPOC), the Director of Security, Estates and Facilities, and through NSS Covid-19 Supplies Portal. Usage and supplies are monitored daily.

Although the hospital acknowledges minimal Aerosol Generating Procedures (AGPs) onsite, it is possible that staff may have exposure through resuscitation attempts or on escort to general hospitals where these are being carried out. To ensure staff safety, a Face-Fit testing programme for FFP3 masks has been undertaken with 80% of ward based nursing staff passing a face-fit test.

3.6 Patient Flow

During the Covid-19 pandemic and given the necessary focus on infection control, patient flow across the forensic estate has decreased. There have been no patients transferred or discharged from The State Hospital and patient admissions have continued.

The following table outlines the high level position from 1 April to 31 May 2020

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds (i.e. those actually available)	107	12	119
Admissions	2	0	2
Discharges / Transfers	0	0	0
Average Bed Occupancy	-	-	95.8.5% of available beds 81.4% of all beds

As part of the wider forensic network, The State Hospital takes part in weekly meetings with Scottish government reviewing care delivery across the forensic estate during the Covid-19 pandemic. On 2 June 2020, it was agreed that the TSH Chief Executive would chair a national sub-group to help facilitate progress in patient flows across the Estate. Representatives of Scottish Government Health Directorate, Forensic Network and Medium and Low security services met on 9 June to progress this work. It is anticipated the process will conclude within 4-6 weeks.

STAFF GOVERNANCE

3.7 Attendance Management

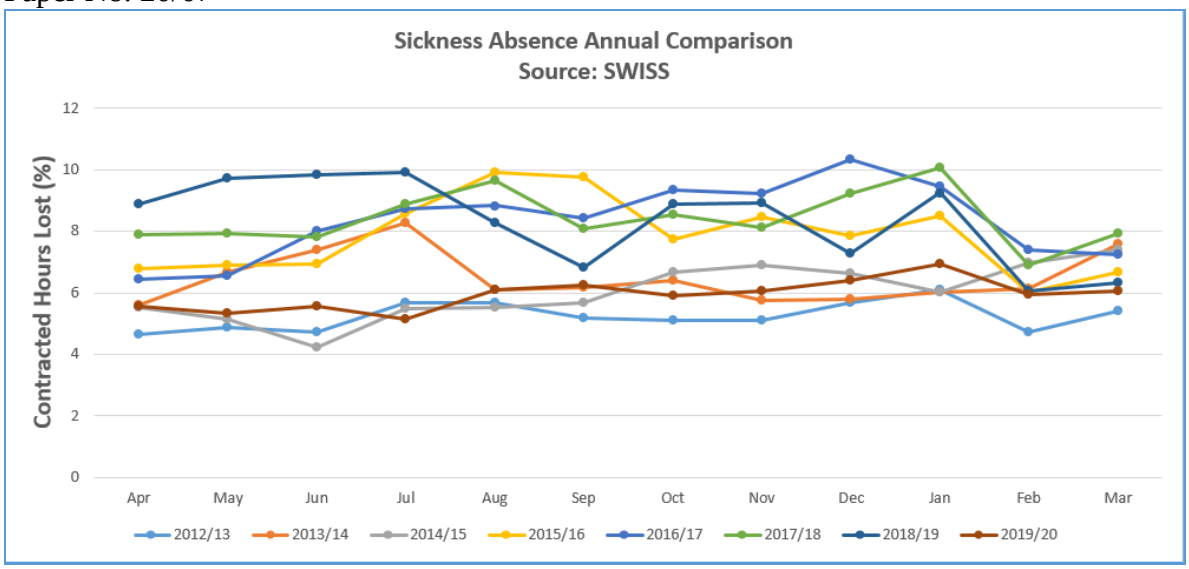
The Board receives an update on attendance management at each Board meeting. This will continue as part of reporting on the response to Covid-19.

Absence data reported is extracted from SWISS, the national source, and SSTS, the local information system. The latest available absence figures are for 31 March 2020.

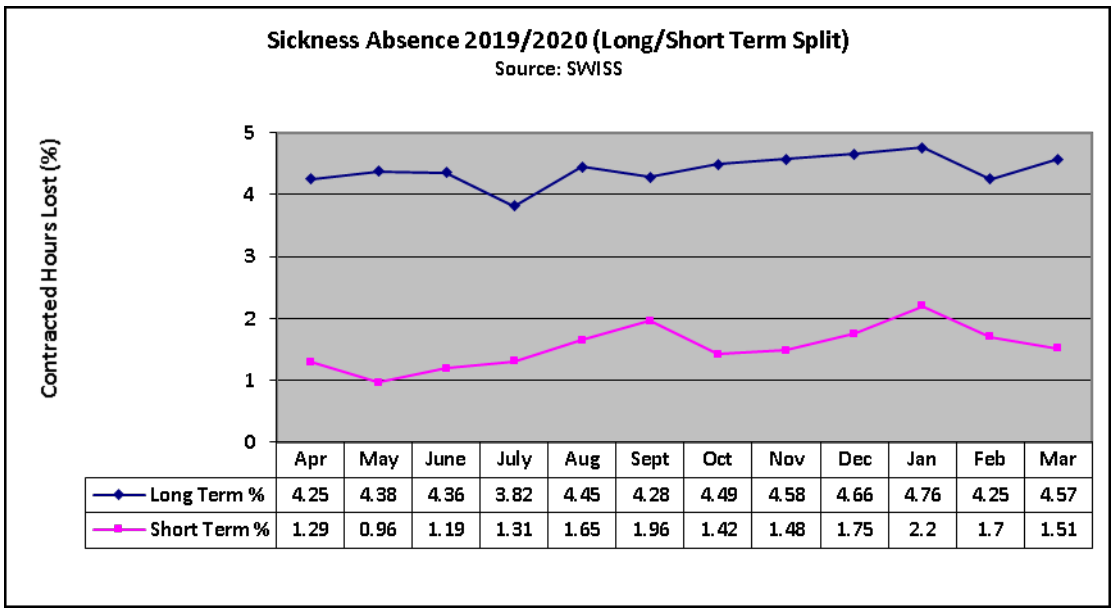
The TSH in-month sickness absence figure for March 2020 was 6.07%, with an average rolling 12-month figure of 5.74% for the period 1 April 2019 to 31 March 2020. The Board should note the local target level is 5%.

The rolling 12-month absence figure represents a reduction of 2.52% when compared to the same period last year (with the rolling absence figure from 1 April 2018 – 31 March 2019 reported at 8.26%).

The March 2020 sickness absence level of 6.07% is the lowest March figure recorded by TSH in the last 5 years (March 2019 - 6.34%, March 2018 – 7.94%, March 2017 - 7.26%, March 2016 - 6.66%, March 2015 – 7.38%, March 2014 – 7.59%).



The long/short term absence split for March 2020 was 4.57% and 1.50% respectively. The chart below provides a monthly comparison of long and short-term absence in the State Hospital for the past 12 months.

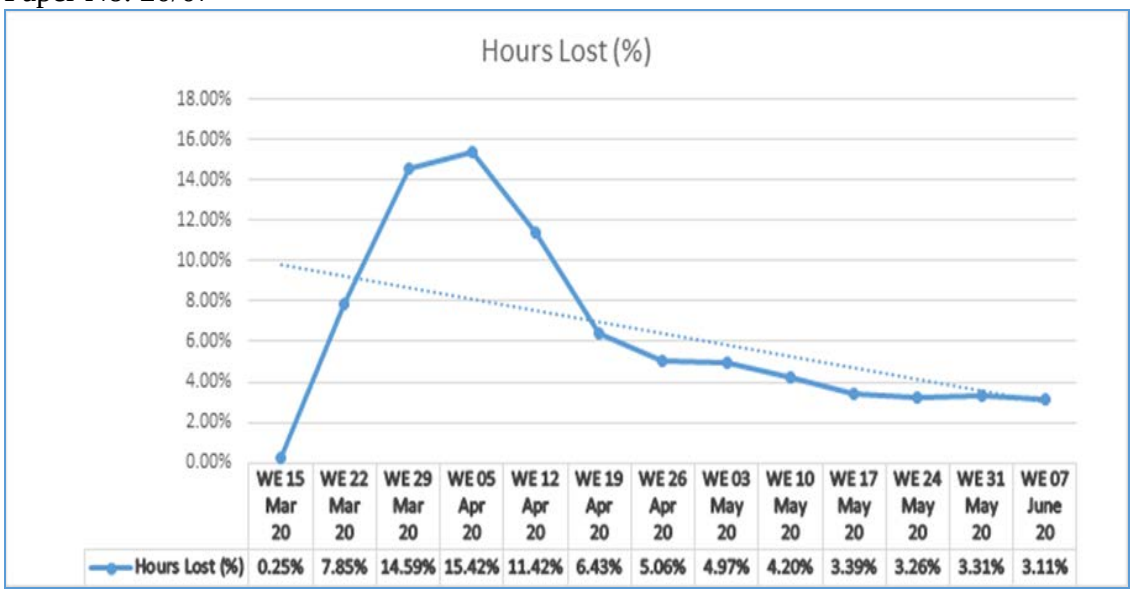


	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Long Term %	4.25	4.38	4.36	3.82	4.45	4.28	4.49	4.58	4.66	4.76	4.25	4.57
Short Term %	1.29	0.96	1.19	1.31	1.65	1.96	1.42	1.48	1.75	2.2	1.7	1.51

The main reasons for sickness absence continue to be Anxiety/Stress/Depression/Other Psychiatric Disorders (37.99%), Musculoskeletal (12.54%) and Gastro-intestinal (8.16%).

Covid-19 Related Special Leave

Details of weekly % work hours lost due to Covid-19 related Special Leave from 15 March 2020 to 7 June 2020 are provided in the chart below. (Source: SSTS)



	WE 15 Mar 20	WE 22 Mar 20	WE 29 Mar 20	WE 05 Apr 20	WE 12 Apr 20	WE 19 Apr 20	WE 26 Apr 20	WE 03 May 20	WE 10 May 20	WE 17 May 20	WE 24 May 20	WE 31 May 20	WE 07 June 20
Hours Lost (%)	0.25%	7.85%	14.59%	15.42%	11.42%	6.43%	5.06%	4.97%	4.20%	3.39%	3.26%	3.31%	3.11%

The Covid-19 related work hours lost includes:

- staff self-isolating due to being symptomatic
- staff isolating due to a household member being symptomatic
- staff who are shielding due to being in a 'high risk' group, or being the main carer for a dependent in a 'high risk' group

3.8 Planning for Extreme Loss of Staff

The Extreme Loss of Staff Plan was developed in response to a significant threat to business continuity as a result of the coronavirus pandemic. A level 2 resilience exercise was held on 18 May 2020 which stress tested The State Hospital's Extreme Loss of Staff Plan.

The scenario started with the duty director being informed by silver command that in the next 24 hours the critical services within The State Hospital would be facing severe staffing issues, bringing the numbers below the absolute minimum required to operate. The staffing numbers given to the duty director were in line with the numbers identified in the Extreme Loss of Staff Plan. Each department was contacted by the duty director to provide a plan to resolve the issue. The exercise ended when it was agreed the hospital could be adequately staffed. The main learning points from exercise included:

- Clarifying absolute minimum staffing numbers and awareness that this number can change depending on the clinical needs of the patients.
- Utilising staff deployment register, managers, supervisors and other departments within the hospital to staff essential services.
- Ensuring daily report is sent to on-call director to give accurate and up to date picture of situation.
- Detailing changes to working patterns.
- Changes in process (i.e. Manual bag searches, closure of staff canteen).

3.9 Staff Recruitment

In line with national directives and the loss of staff plan, recruitment of nursing staff has been a priority.

Student nurses' roles have been adjusted, with them now completing the last 6 months of their education in clinical practice, working directly as part of ward teams. They are employed by the

Board at band 4 level. 12 Students started work in this capacity in April 2020, as well as one Occupational Therapist joining through the same route as it is also open to AHP students. On 18 May, a current Nursing Assistant progressed to a second year Nursing Assistant contract.

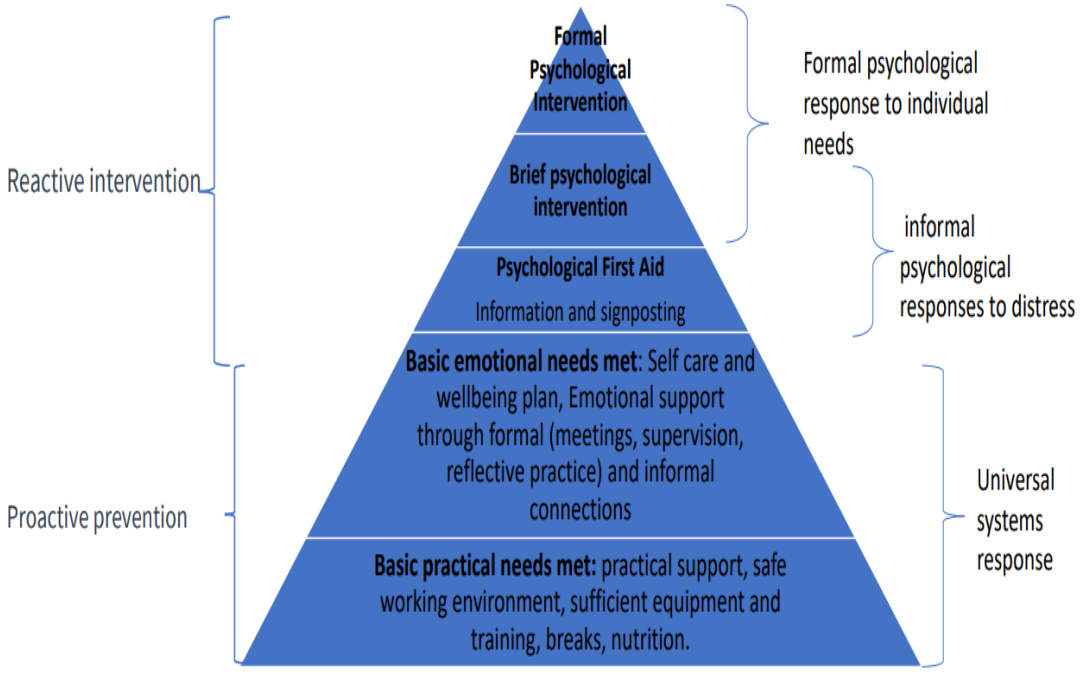
Six Nursing Retirees and 1 Security Team Leader returned on 3 month temporary contracts from 01 May 2020 although one Nursing Retiree subsequently withdrew after completing the induction.

Human Resources have continued to take forward the recruitment process for positions confirmed prior to the Covid-19 pandemic with new employees joining TSH from across a range of disciplines including risk management, sports rehabilitation, crafts, portering and administrative roles.

3.10 Staff Health and Wellbeing

A tiered model has been adopted locally to support employee health and wellbeing throughout the pandemic. This is based on guidance produced by NHS Education for Scotland and the British Psychological Society. The model includes initiatives and interventions designed to raise staff awareness and facilitate access to self-help resources, psychoeducation and peer support. Signposting and assistance to access psychological support and counselling services is also being provided when required.

Responding to staff distress – a stepped care model (NES, 2020)



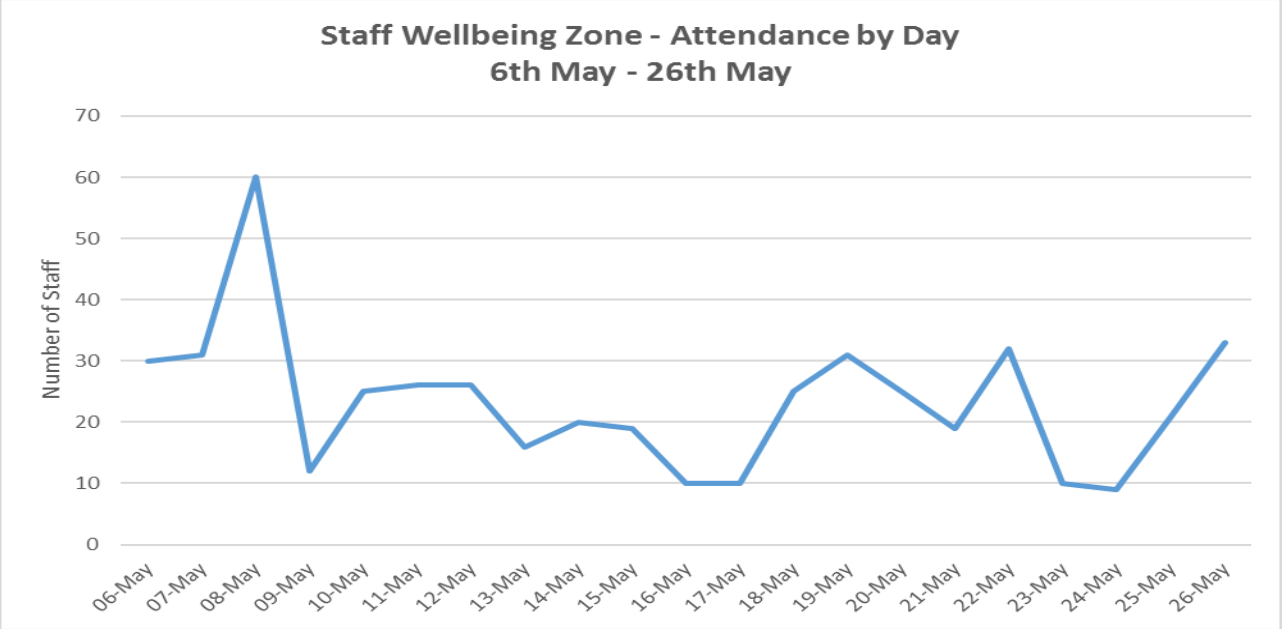
The key support measures that are currently in place within The State Hospital are outlined below.

3.10.1 Staff Wellbeing Zone

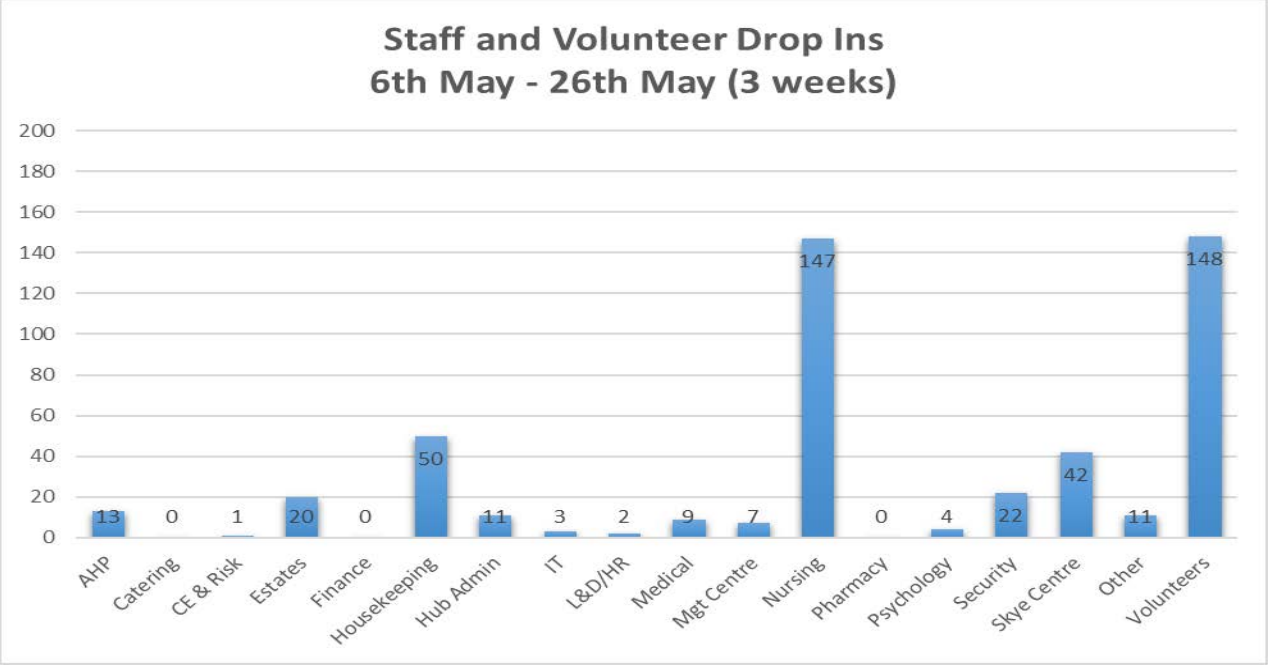
The Staff Wellbeing Zone was launched on 6 May 2020 and has been extremely well-received by staff throughout the hospital. This resource aims to provide a space for staff to relax and recuperate away from their work environment, and to make it as easy as possible for individuals to

access the support they need. As of 26 May 2020, there had been a total of 342 visits to the wellbeing zone. A further 43 staff have signed up as volunteers to provide peer support within the wellbeing zone (with approximately 24 volunteers providing sessional support each week).

The chart below provides details of the number of visits per day to the wellbeing zone and indicates sustained utilisation of this resource since it was launched.



Details of the number of visits to the wellbeing zone by staff group are provided in the chart below. It indicates that the zone is being accessed by staff members from the majority of disciplines across the site.



**volunteers refers to staff volunteers to the drop in centre.*

It is important to note that there has been a great deal of support from Lead Nurses, Senior Charge Nurses and other line managers in promoting the wellbeing zone and encouraging staff to attend.

Line managers within departments/disciplines with low attendance rates have been contacted to encourage use of the wellbeing facility amongst staff within their department. Specific enquiries have also been made regarding potential reasons for low attendance and to discuss how we might provide support to staff within these groups.

Given the emerging evidence that people from BAME backgrounds may be disproportionately affected by Covid-19, additional signposting resources are being added within the wellbeing zone to support staff from Black and Minority Ethnic Groups (BAME). Information is also provided in relation to finance, domestic violence, advice on alcohol use, and guidance on how to donate money to various causes. Details on how to access food banks are available, and a basket is available for staff to donate goods to our local food bank. This reflects the practical approach that is being adopted within the wellbeing zone and feedback suggests that this is working well for our staff.

Feedback received from staff volunteers indicates that the zone has been well received by staff due to the informal and welcoming nature of the area and resources available, the feedback also highlights that volunteers, as well as visitors to the zone, are benefitting from this resource.

In addition to the above, a total of 51 staff have accessed the virtual wellbeing zone that has been developed on the learnPro platform. This was created to provide access to the information and resources currently located within Islay to staff who are shielding or working from home, or who are unable for other reasons to access Islay. The viability of 'virtual' support sessions to provide support to staff within the shielding category is also currently being explored.

All staff visiting the wellbeing zone, or accessing the virtual zone on learnPro, are being entered into a prize draw/raffle. The prizes have been donated by local businesses and people who staff know personally. The kindness of individuals has been outstanding and it is planned to send out formal thank you letters to those that kindly donated the prizes. This venture has proved very successful in enticing staff to visit the wellbeing zone and subsequently look at the resources and talk with the peer support volunteers.

3.10.2 National Wellbeing Champions Network & Wellbeing Hub

The National Wellbeing Hub was launched by the Scottish Government on Monday 11 May 2020. This is a new online platform that provides signposting to the wide range of support and wellbeing services and (self-care) 'tools' available across health and social care organisations in Scotland. Since it was launched, the site has had over 82,299 page views.

Work is currently being progressed nationally to enable hub usage data to be reported by individual NHS Boards. Other areas that are being addressed by the national Champions Network include:

- *Communications Toolkit* – A national communications toolkit has been developed to support key messaging in relation to Covid-19. Printed copies of the toolkit are available within the wellbeing zone, and other resources and information within the wellbeing zone have been categorized in line with the toolkit. An online version of the communications toolkit is also accessible within the virtual wellbeing zone on learnPro.

- *National Listening Helpline* – a new national helpline is currently under development. This is based on the NHS24 health hub model and will be accessible to all health and social care staff 24/7. It is designed to compliment existing resources within NHS Boards and will be available for 1 year from the end of June 2020. Staff within The State Hospital also continue to have access to NHS Lanarkshire's confidential 24hr Helpline/Listening Service.

3.10.3 NHS Charities Together Funding Grant

A range of suggestions have been put forward by staff on how to utilise the funding grant of £35,000 from the NHS Charities Together Covid-19 Appeal. The funding can be used to support projects and equipment aimed at enhancing the well-being of staff, patients and volunteers affected by Covid-19. Suggestions received to-date are noted below.

A short life working group has been formed to review the suggestions that have been received. The review panel will be chaired by the Wellbeing Champion (Nurse Practice Development Lead). Membership of this was agreed through Gold Command and comprises the Director of Nursing & AHPs, Finance and Performance Management Director, Interim HR Director and Employee Director.

3.10.4 Supervision and Reflective Practice

Supervision and reflective practice are recognised as essential aspects in supporting staff mental health and wellbeing within care settings. Efforts have been made to ensure continued provision of this support during the current pandemic.

3.10.5 Support for Leaders and Frontline Managers

Options for enhancing support to leaders and frontline managers within The State Hospital are being explored through Gold Command. Key priorities include provision of training on Psychological First Aid and coaching support for managers. To-date, a total of seven managers within The State Hospital have registered to participate in the 'Coaching For Wellbeing' digital coaching service being delivered through Project Lift.

A series of new online workshops on 'Caring Human Factors' that have recently been launched by the Royal College of Physicians will also be promoted across the leadership and frontline manager cohort.

3.11 Staff Engagement

To support recovery and renewal planning and engage staff to ensure learning for the current situation informs future plans, a series of staff engagement activities have taken place across The State Hospital. The 'Command Structure' is a significant step away from the consultative management approach that the organization has been aiming to establish through the Clinical Model redesign process. The staff engagement activity provided an opportunity to 'check in' with staff and understand their experience of the recent changes.

Emerging themes from staff engagement will be considered from a strategic planning, quality improvement process and innovation perspective to identify the strategic and process responses to support quality of care, innovation in practice and system redesign. Feedback from patients and carers will also be used to inform future developments.

3.11.1 Staff Survey

A staff survey was developed to gather feedback on the following:

- *What is going well and why?*
- *What new practice would you want to embed in future working?*
- *What would we need to change or amend as we continue in the current situation?*

Over a six week period, 39 responses to the staff survey were received, nine teams and 30 from individuals. From these a series of themes emerged which include:

- Communication
- Activity for patients
- Technology enabled flexible working practices
- Organisational culture, values and behaviours
- Staff wellbeing

Building on these themes a series of 13 conference linked discussions, each led by the Chief Executive, have taken place between the 27 May and the 8 June 2020, involving over 150 staff form a wide cross section of teams across the organisation.

The main themes from the staff survey were used as a baseline for discussion and staff were asked to feedback what was important to them moving forward, what they would want to build on and embed in future work and what they would not wish to see a return to. Members of the Quality Forum engaged in these discussions to reflect a QI approach to planning for recovery. Staff side were also engaged in the discussions to ensure a partnership approach.

3.11.2 Summary of Staff Engagement Sessions

The staff engagement exercise has been positively received, with many respondents identifying areas of creative and innovative practice as a result of changes to care and service delivery. The opportunity to change some aspects of how the organisation delivers care and services in the future were identified and an overall impression that staff were keen to pursue a process of change was apparent. Through the discussions, staff identified what was important to them, what they would seek to embed in future practice and what they would not want a return to when The State Hospital progressed to remobilisation and easing of restrictions.

The following sections are a summary of the answers given during these sessions in reference to their respective question and discipline.

What is important to you as we transition into a period of recovery and renewal?

- TSH should capitalise on the flexibility we are currently offering and ensure our ways of working are efficient.
- Streamline the decision-making process, meetings and approval routes to reaffirm the value of these areas, which should only include high-value options.
- The additional 1:1 session with patients has benefitted their mental and physical wellbeing, which is a result of the new and innovative ways of working through restrictions.
- Greater engagement in the data from wards and supportive departments that may affect frontline duties and responsibilities is key to fluidity in their day-to-day activities.
- Home/remote working should continue and be a permanent working option at TSH for those applicable.
- Utilise the IT available to staff at TSH and further develop our options going forward to become more efficient.
- Continue with the catering option at present as this is an excellent example of minimising infection control and patients really benefit from their portions being separate.
- The wards continue to feel safer thus less anxiety from staff who now feel secure and supported in their roles.
- Communication with staff and patients is key to moving forward during this period.
- Multi-disciplinary working should continue with input from all professions in facilitating patient activity and movement.
- Embrace change in the future as a positive aspect for better delivery in care and services.

- Continue to put patients' needs at the centre of how we shape care and services
- Restart some groups e.g. patient learning, spiritual care
- Take time to pause and restart the activities that add value and review the ones that don't.
- Continue to build on improvements in relationships between patients and colleagues

Is there a new practice you would like to embed in the future as a new venture?

- Comprise a seasonal timetable for patients regarding grounds access and outdoor activities that encompasses the climate.
- Introduce longer working days that exceed beyond the normal 9-5 to offer more opportunities for the patients and greater flexibility for staff.
- Create a 'protected time' slot for clinical reflection.
- Having the ability to come into work on the weekends as opposed to the regular Mon-Fri 9-5 timeframe to offer more flexibility to staff once restrictions relax.
- Increase the equipment available for nurses regarding changing into the uniform on hospital grounds e.g. extra hanging hooks, benches, shoes racks etc.
- Offer a dual-running approach of Skye Centre activity and patient walks and allow patients to decide what they wish to participate in.
- Training for home/remote workers which outlines the etiquette of this working practice.
- Allow patient grounds access from the outset of their time at TSH and change the ethos surrounding good behaviour and forgo considering grounds access as a 'reward'.
- Electronic prescribing would allow for easier monitoring of what is being prescribed which should coincide with patient needs.
- Create a balance of routine and flexibility for patients by devising bespoke care plan for their mental and physical wellbeing needs.
- Devise a new procedure for visiting whereby there be limits on what can be brought into the hospital to limit the facilitation of extra searches and security presence.
- A Sunday Service for patients and carers
- Investment in new technology to support communication, digital connectedness and work processes.

What would you not like to see going forward?

- The degree of autonomy in practice for decision making and lack of input from frontline/clinical staff during change and patient processes.
- The volume of meetings that are of low value should not return.
- The drawn-out version of recruitment should reduce to smaller timescales.
- Patient access to takeaways should be restricted to address their diet and health needs.
- The current CPA process is often considered a paperwork exercise thus modifying this would enable a more efficient approach.
- Review volume of meetings on a Monday to allow for more 1:1 opportunity to actively engage with patients to fully understand their changing needs.
- The errors during note taking of CPA through phoning in via teleconference has a continuous effect on other clinical teams thus more contact during these is needed.
- Disconnected feeling in some departments due to restrictions on wards has a negative effect on communication with the wider clinical teams.
- Medicines currently being ordered are no longer needed as pharmacy are unable to have access to wards and waste increases as a result.
- Lack of knowledge surrounding key roles within the hospital to increase fluidity and understanding.

3.11.3 Main themes emerging from the responses

Through the staff engagement activity, a range of themes has emerged. These are listed below:

- Digital transformation
- Video visiting
- Multidisciplinary working and peer relationships
- Flexible working
- Build a personalised approach to care
- Increase in patient activity and improve physical health of patients
- Organisational efficiency and reduction/ review of low value activities
- Organisational leadership and culture
- Communication
- Pace of change
- Safety onsite

To address these themes and develop a strategic approach that enables and authorises change, there is a need to collaborate on the creation of the renewal plan to provide a route for staff to engage with this. Further engagement and communication activity will ensure a cohesive and identifiable brand for the renewal programme and the strategic approach will express a common aim to enable staff to connect to the vision for change and own the process. Feedback will be provided to staff to share themes expressed through the staff engagement activity. The strategic approach will connect and sequence activities and change ideas, take a quality improvement approach, prioritise and describe work programmes and provide a timeline for activities.

3.11.4 Staff Wellbeing Questionnaire

NHS Boards are being asked by Scottish Government to measure staff experience and to report on the impact of Covid-19 related support measures being put in place. In addition to the staff engagement exercise, a proposal was approved by the Research Committee for a local health and wellbeing survey, focussing on individual health and wellbeing. This will take the form of a short questionnaire and will present a mechanism to measure the impact and effectiveness of the health and wellbeing support interventions that have been put in place.

3.12 Communication

Communication of information and decisions from the Gold and Silver Command meetings as well as the Hospital Huddle are shared through staff via bulletins. These include any national updates together with TSH specific information. Initially these bulletins were released twice daily, and this has now reduced to one bulletin a day and this reflects the reduction experienced in the flow of Covid-19 related information. Each Bronze command has continuing responsibility to ensure that their teams are briefed regularly on key developments, and do so through the existing line manager and team structure of the hospital.

The Covid Support Team are well established as an important source of additional support to staff, providing information and advice. Regular meetings take place with staff side representatives to enable resolution of issues in a timely fashion.

Gold command requested that a SLWG take forward a proposal to implement modern effective communication platforms for the organisation. Examples given were the use of a YouTube channel where relevant common materials can be shared and viewed, including short video messages, latest news and information, educational resources and feedback from staff. Work has commenced

with the SLWG to assess whether possible within TSH. The SLWG have also been asked to explore other social media platforms to aid the flow and effectiveness of communication.

3.13 Impact of response to Covid – 19 on business continuity and Remobilisation Planning

As outlined, operational management of the hospital continues to be led by the Incident Command Structure, headed by the Chief Executive for Gold Command. The Board received reporting on 23 April that the TSH operational governance structure was paused and leadership of ongoing workstreams required were subsumed into the command structure.

In response to guidance from the Cabinet Secretary for Health and Sport, and in line with all other NHS Boards, TSH submitted a draft Interim Remobilisation Plan on 25 May 2020. This sets out a roadmap for TSH for remobilisation and aligns with the national position. Board Members have received copies of this draft plan, to seek their views and endorsement of the direction of travel. Subject to endorsement from the Board, the Chief Executive will engage further with Scottish Government in this regard to finalise planning and lead this through Gold command, ensuring that the Board remains fully informed of progress.

The indicative schedule to restart some workstreams is on a phased basis across the hospital. It is recognised that this will entail dual working as TSH continues to respond effectively to Covid-19, as well as initiating a restart programme of workstreams. The Chief Executive is leading a review of resourcing and budgetary impacts to ensure that the organisation can progress remobilisation from a resilient platform.

Remobilisation will include some groups and committees progressing on digital platforms. Structures should promote fluidity of decision-making within the appropriate governance framework. Feedback from the ongoing staff engagement exercise indicates that staff and teams would welcome a refresh of the extant ways of working across the organisation in light of the innovative working models introduced in response to Covid-19. This should be supported and underpinned by effective and transparent decision making, engagement and communication. Remobilisation planning should recognise the positive nature of partnership working through the incident command structure to enable continuation of this to support this during remobilisation and the formation of the ‘new normal’ for The State Hospital.

4 RECOMMENDATION

The Board is invited to:

1. Review and discuss 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. Endorse this position as an appropriate framework for continued operational management and governance during the Covid-19 pandemic.

3. Endorse the strategic direction outlined in the draft TSH Interim Remobilisation Plan.

4. Outline any additional reporting requirements required.

Paper No. 20/07

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support operational management and corporate governance structure of the NHS Board durtinf Covid 1-19 emergency response
Workforce Implications	Considered in this report
Financial Implications	Financial implications outlined within assessment section
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)	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 HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	18 June 2020
Agenda Item:	Item No. 7b
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Director of Finance and Performance Management
Title of Report:	Financial Governance – Covid-19
Purpose of Report:	Update on current Covid financial impact

1 SITUATION

There were additional costs incurred in the final month of the financial year 2019/20 which are regarded as being specifically due to the Covid-19 crisis, together now with ongoing 2020/21 monthly recurring costs as the Hospital operates under new ways of working.

2 BACKGROUND

These costs for 2019/20 and 2020/21 have been formally reported to the Scottish Government's Covid-19 Health Finance team within the Health Finance and Infrastructure Directorate, and feedback / discussion has followed directly on these reports.

The next report will be due in the second half of June – notifying costs to the end of May for update – and then, once the Q1 results are reported in July, there will be a national review of Boards positions at that point from an NHSScotland budget perspective, in line with the outcomes of Board peer-group reviews currently getting underway to review consistencies of reporting. This is regarded as the next key stage in assessment of Board Covid costs.

3 ASSESSMENT

3.1 Financial Governance

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

During March - May, the revenue costs noted in paragraph 3.2 below were specified in the Hospital's Covid19 returns.

It is understood that those ongoing in 2020/21 should, in due course, be reimbursed from the Scottish Government's share of in excess of £5bn being provided by the UK Treasury (Barnett-based – approx. £430m). However, the position on this remains to be finalised and communicated formally by SG Health Directorate.

3.2 **Covid19 costs**

As noted above, costs incurred in relation to Covid19 in March – May 2020 – are now awaiting confirmation of reimbursement from the Interim Director of Health Finance and Governance.

During this period, the undernoted revenue costs are specified in the Hospital's returns.
i – Overtime costs March £170k, April £150k, May (estimate) £175k – additional overtime was incurred each month due principally to the increased levels of staff absence, together with an element of high level clinical demands;
ii – Delayed annual leave £44k – increased year-end accrual for staff leave due in March now deferred due to staff required to be on-site or absent through sick leave;
iii – Covid-19 support team £35k per month – in March the Hospital established a specific team to provide support to the management of the Covid-19 crisis, comprising 9 members of staff seconded from various departments;
iv – IT costs £20k – additional equipment (laptops, mobile phones, licences etc.) was necessary in order to facilitate remote working for a number of staff and other essential IT site requirements;
v – Equipment costs £8k – this includes new monitors, some pandemic PPE stock, uniforms, and patient tvs/radios;
vi – Estates/facilities costs £6k – including the requirement for additional lockers, trolleys, chairs etc.
vii – Recruitment of an additional 12 student nurses on 6-month contracts – to be funded by NES - as part of a national initiative to support Covid pressures – estimated cost for 6 months £260k (£43k per month).

Currently, the above items i, iii and vii are ongoing, together with additional individually identified costs for deep cleaning, drugs, oxygen, specific equipment, increased teleconferencing and potential delay costs should the perimeter security refreshment project be affected by restricted or rescheduled site access at any time.

Future costs
In addition, further to recent Directors' discussions, the Hospital is now assessing the potential future financial demands required of any staffing restructure or additional posts which will result from the ongoing crisis. While as noted in item iii above there is a Covid-19 support team in place, these staff are all redeployed from other departments – where their normal workload is either stalled or undertaken by others in the team, with no backfill in place.

Directorates are therefore considering what is required going forward to support the new ways of working, and these will be discussed, reviewed, and considered for inclusion in our Quarter 1 Covid19 financial submission to SG in July to ensure that TSH costs are appropriately recognised and funded.

4 RECOMMENDATION

The Board is asked to note 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/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Finance and Performance Management 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. 20/28

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2020
Agenda Reference:	Item No. 8
Sponsoring Director:	Medical Director
Author(s):	Medical Director/Clinical Effectiveness Team Leader
Title of Report:	Clinical Governance Annual Report 2019/20
Purpose of Report:	For Decision

1 SITUATION

The attached Clinical Governance Committee Annual report outlines the wide range of activity overseen by the Committee during 2019/20. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

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

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

3 ASSESSMENT

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

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

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

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

Proposed Quality Headings for Future Clinical Governance 12 Monthly Reports
Looking for approval to start using these from August 2020

4 RECOMMENDATION

The Board is asked to approve the Governance Reporting Arrangements, Terms of Reference, Programme of Work, Clinical Governance Committee Annual Report and the new proposed headings for 12 monthly reports.

Paper No. 20/28
MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT

1 April 2019 – 31 March 2020

1. Introduction

The State Hospital, like all NHS organisations, has a statutory responsibility to establish clinical governance arrangements to ensure continuous improvement in the quality of care and treatment provided to patients. The national requirements for clinical governance have been the subject of substantial guidance, from the *Clinical Governance and Risk Management Standards* published by NHS Quality Improvement Scotland (NHS QIS) in 2005, to *Better Health, Better Care*, published by NHS Scotland in 2007, and subsequently through the Scottish Government's publication of the *Healthcare Improvement Strategy for NHS Scotland* in 2010 which outlines 3 main quality ambitions:

1. Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.
2. There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.
3. The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

The underlying principle of effective clinical governance is that systems and processes provide the framework for patients to receive the best possible care. This report provides an overview of the work of the Clinical Governance Committee during 2019/20 and examples of good practice and matters of concern

2. Committee Chair, Committee Members and Attendees

Committee Chair
Nicholas Johnston, Non-Executive Director

Committee Members
Maire Whitehead, Non-Executive Director (Until 29 February 2020)
David McConnell, Non-Executive Director
Brian Moore, Non-Executive Director (from 1 February 2020)

Attendees
Terry Currie, NHS Board Chair
Gary Jenkins, Chief Executive
Prof. Lindsay Thomson, Medical Director
John Marshall, Head of Psychological Services
Mark Richards, Director of Nursing and AHPs
Robin McNaught, Finance and Performance Director
Dr Khuram Khan, Chair of Medical Advisory Committee
Monica Merson, Head of Business Support and Corporate Planning
Sheila Smith, Clinical Effectiveness Team Leader

3. Meetings during 2019/20

During 2019/20 the Clinical Governance Committee met on 4 occasions, in line with its terms of reference. Meetings were held on:

- 9 May 2019
- 15 August 2019
- 14 November 2019
- 13 February 2020

4. Reports Considered by the Committee During the Year

All 12 monthly rolling internal governance reports are submitted using the following headings:

- Introduction
- Governance arrangements
- Committee membership
- Role of the committee
- Aims and objectives
- Patient Voice
- Meeting frequency and dates met
- Strategy and workplan
- Management arrangements
- Key pieces of work undertaken during the year [include outcomes]
- Key performance indicators [with data]
- Comparison with last annual report
- Areas of good practice
- Identified issues and potential solutions
- Future areas of work and potential service developments
- Implications
  - Staffing
  - Finance
- Next review date

4.1 12 Monthly Internal Governance Reports

Fitness to Practice
The Committee received a report in relation to Fitness to Practise at its May 2019 meeting. The reporting period covered was 1 April 2018 - 31 March 2019. The report was submitted to the Committee for information in respect of the process for monitoring professional registration status at The State Hospital thus providing assurance that all relevant staff hold current professional registration as appropriate. It was proposed that further reporting would include social work and pharmacy staff. The Committee noted the report and agreed that it should also be flagged to the Staff Governance Committee.

Infection Control
At the May 2019 meeting, the Committee noted the progress in the Infection Control Annual Report 2018/19 (covering 1 April 2018 - 31 March 2019) and endorsed the Programme of Work for 2019/20. The report outlined the wide range of Infection Control activity undertaken within the Hospital and summarised the work conducted by Infection Control Services. Key achievements over the year included increase in the uptake of flu vaccinations for nursing staff, a positive audit into the dress policy following an HEI recommendation regarding the wearing of wrist watches, review of the procuring of patient equipment, review / audit of patient carry out meals and the water safety group review of the risk assessment. Assurance was also given following the HEI inspectorate visit to Queen Elizabeth University Hospital that there were no similar areas of concern at The State Hospital.

The Committee noted two areas of concern: hand hygiene within the Skye Activity Centre and SIPSEP training compliance had decreased over the past 12 months. The Committee asked for specific assurance from the Infection Control Committee on these two points.

Research Committee/Research Governance and Funding
In May 2019 the Committee received and approved the 2018/19 Research Committee Annual Report. The reporting period covered was 1 April 2018 - 31 March 2019. The main areas of focus were the range of research activity, its dissemination undertaken by The State Hospital staff over the period of 2018/19 and the implementation of research findings into practice.

The report also provided details of the annual Research, Clinical Effectiveness and Quality Improvement Conference, and the Forensic Network Research Conference. As requested by the Clinical Governance Committee, the report also specifically addressed additional ways to monitor performance.

Duty of Candour
The first annual report for Duty of Candour was tabled at the May 2019 meeting. The report covered information on the policy, training that had been implemented across the site as well as the governance and monitoring arrangements. Between 1 April 2018 and 31 March 2019 the Risk Management Department forwarded 128 incidents for consideration by the Duty of Candour Group, none of which fulfilled the criteria for Duty of Candour, i.e. an unintended or unexpected act incident that resulted in death or harm, as defined within the Act, and did not relate directly to the natural course of a person's illness or underlying condition.

Patient Safety
In August 2019 the Committee received and approved the Patient Safety Report covering the period 1 July 2018 - 30 June 2019. During this period, in February 2019, a re-launch of the Patient Safety Programme safety principles was undertaken. The 4 principles are now: Communication; Leadership and Culture; Least Restrictive Practice and Physical Health. The report showed that these principles fit well with the Board focus and would not require any changes to current governance arrangements. These existing arrangements include a bi-monthly meeting of the Patient Safety Group who are taking forward work in relation to: Introduction of Patient Support Plans; Leadership Walkrounds; Observation Practice from observing to intervention, with Policy Development and practice change underway for this. It was also noted that the Dynamic Appraisal of Situational Awareness (DASA) as part of the Tableau Project has received positive feedback and work continues on this.

Forensic Network Medium and High Secure Care Review Visit – Action Plan
At the August 2019 and February 2020 meetings the updated actions from the Forensic Network Peer Review Visit were tabled for information. By February 2020 there were 10 actions outstanding from the original 37. Work has commenced to close off the last remaining actions. It was noted that presenting the action plan at the Clinical Governance Committee has driven the actions forward in a more timely manner than the previous visit actions.

Medicines Committee
In August 2019 the Committee received and noted information on the key pieces of work undertaken throughout the period 1 October 2018 - 30 June 2019 by the Medicines Committee. The Medicines Committee oversees all aspects of medicine throughout the hospital including their effective and economic use, policies and clinical audit. Key areas of work this year have included a significant clinical audit work programme, medicine supply planning, progression of the Medication Incident Review Group and the new prescribing guidance documents. Core ongoing medicines management work on expenditure and formulary usage remains in place with positive results. The report noted that in the coming year, as well as the regular work plan, there will be work undertaken around electronic prescribing advances, the new national contract for Clozapine, an update of the independent prescriber framework and updating of the Safe Use of Medicines Policy.

CPA/MAPPA
At the November 2019 meeting the Committee noted the report covering the period 1 October 2018 - 30 September 2019 and supported the future areas of work. 100% of transfers were managed through the CPA process during the reporting period. The report identified a number of key areas in relation to Multi Disciplinary CPA attendance, Patient and Carer Involvement and Strategic Engagement and Representation. With regards to MAPPA, Social Work continued to meet their obligations. During the review period no patients had been identified as potentially meeting the risk of serious harm category, however all patients remain under consideration in this regard and consultation takes place with the relevant MAPPA Co-ordinators as appropriate. Future areas of work included review of the MAPPA processes.

Child and Adult Protection
The Committee received and noted the report in November 2019 that covered the period 1 October 2018 – 30 September 2019. The report highlighted key areas of work that included key achievements in the areas of keeping children safe and adult support and protection. A training update was given that highlighted improvements for the completion of online modules and attendance at the Keeping Children Safe Training and Adult Support and Protection Training. Both of these were half day courses. Future areas of work included review of both the Keeping Children Safe Policy and Adult Protection Policy as well as further migration of Child and Adult Protection related templates etc from Word based documents onto RiO.

Physical Health Steering Group
In November 2019 the Committee received and noted the 12 month rolling report from the Physical Health Steering Group covering the period 1 October 2018 - 30 September 2019. The report noted the developments and progress made in the 5 key strands for which the Physical Health Steering Group had responsibility. These related to Primary Care (including long term conditions); Physical Activity; Nutrition and Weight Management; Food, Fluid and Nutrition and National Guidelines and Standards. For each of these areas, details were provided of the work undertaken and the performance against local performance management targets. Key pieces of work for the next 12 months will be: to establish the remit of 'Counterweight Plus' as an evidenced based weight loss intervention for obesity and those with pre diabetes (diagnosed up to 6 years); embedding the Healthy Weight Management Plan into practice, monitoring implementation, robust evaluation and audit of compliance rates and delivering the proposed 9 health improvement events as no events were delivered last year due to staffing challenges.

Rehabilitation Therapies Service
In November 2019 the Committee approved the report covering the period 1 October 2018 – 30 September 2019 and endorsed the future areas of work and service developments contained within it. The report provided a summary of the key areas of work that included agreement of a new AHP Workforce Plan and the subsequent appointments of Lead Occupational Therapist, Speech and Language Therapist and recruitment to vacant posts; appointment of Occupational Therapist to the Skye Activity Centre in February 2019 resulting in development of employability opportunities and the development of an Events Committee to co produce evening activity events and the successful AHP Team Development poster presentation to NHS Scotland Event on 30/31 May 2019. Future areas of work for the service included: the implementation of recovery through activity manualised group intervention; increase the employability opportunities; complete an audit against the Royal College of Occupational Therapists secure standards; increase number of staff throughout the hospital trained in talking mats to aid communication and implement 400 yard campaign to increase wellness and reduce functional decline.

Clinical Governance Group
At the February 2020 meeting the Committee received and noted the 12 monthly report from the Clinical Governance Group covering the period 1 January 2019 - 31 December 2019. The report provided a summary of the work of the Clinical Governance Group over the past 12 months. As well as overseeing the reports that go to the Clinical Governance Committee other key pieces of work included: ensuring that the patients' day project was progressed and assisting in agreeing the option that should be progressed to take the project to the next stage; ensuring the review of the Clinical Model is robust and engagement is at the forefront of the project, ensuring the next phase of the Supporting Health Choices Plan includes a workshop to agree new recommendations, ensuring the RSM Audit results are progressed through the Skye Activity Centre data; providing a discussion forum for digital inclusion within The State Hospital; ensuring the Psychological Therapies Service is continually reviewing and improving their service and the group also ensured that all action plans were closed in a timely manner through more regular progress updates.

Mental Health Practice Steering Group
A report was submitted to the February meeting covering the period 1 November 2018 - 31 October 2019. The key pieces of work from the group included: monitoring of the outcome measures with improvement plans agreed where appropriate; implemented updated patients' admission guidance aimed at supporting the earliest possible engagement in activity for all newly admitted patients; a small scale test of change was carried out as part of the TSH3030 initiative to trial a process to more effectively tailor the CPA meetings to the needs of the patients; moving from quality assurance to quality improvement with advance statements that are held for our patients; supporting the delivery of the realistic medicine within the hospital and a piece of work to ensure that the development of any clinical practice takes cognises of the 'What Matters to Me' feedback. Future areas of work will include identifying opportunities to support continuity of clinically relevant 2019 TSH3030 projects; informing the development of the implementation plan for the new Clinical Care Model; contributing to the development of the new Carers' Policy and supporting the Triangle of Care assessment and contributing to work streams emerging from same.

Psychological Therapies
At the February 2020 meeting the Committee noted the Psychological Services report covering the period 1 January 2019 - 31 December 2019. The report was centred on the 6 quality dimensions from The Healthcare Quality Strategy for NHS Scotland. Key service developments during 2019 included: a formulation quality audit comparing formulations to the ideal and using a QI audit process to improve them - no other service in the UK or Ireland is taking this transparent iterative improvement approach to clinical formulation; ensuring that state of the art and science sexual harm psychosocial treatment were delivered to patients as appropriate, along with novel evaluation methods using case study methods; the service contributed to the agenda of reducing patient obesity by implementing evidence based interventions with ward staff such as MAP (motivational approach to behaviour change which is approved by NES for improving a range of physical health problems); adaptation to assessment and interventions to meet the need of the new clinical model ID service through implementation of the Positive Behavioural Support (PBS) model and the completion of an audit on all research activity for the previous 5 years and how many studies were published.

4.2 Standing Items Considered by the Committee during the Year

Category 1 Reviews
Two Category 1 Review reports were considered during the reporting year. All had their recommendations and actions agreed. There were concerns noted over the length of time it is taking to complete the Category 1 Review process. Further work will be undertaken during 2020 to review the Category 1 Review process. The Committee also followed the progress of the actions resulting from a Category 1 review in 2018 that was undertaken by external reviewers.

Learning from Complaints
The quarterly Learning from Complaints report was considered and noted at the Clinical Governance Committee at every meeting. Actions arising from all complaints are included within the report to share the learning which enables the organisation to develop services which take cognisance of complaint outcomes. The report is based on the two stage model that enables complaints to be handled either locally, by front line staff, allowing for *Early Resolution* (Stage 1) within 5 working days, or for issues that cannot be resolved quickly or are more complex, by *Investigation* (Stage 2) within 20 working days. All responses that have been received through the Complaints Experience Feedback Forms from patients/carers are also included within the reports.

Learning from Feedback
The quarterly Learning from Feedback report was considered and noted at the Clinical Governance Committee at every meeting. These reports highlight the feedback received,

encompassing concerns, comments and suggestions, (including evaluation forms) and any compliments / positive feedback received. The report notes the outcome from all feedback and any lessons that have been learned by the hospital. It was noted at the February 2020 meeting that going forward the report will adopt a triangulated approach to analysing feedback emerging from: feedback processes, complaints handling and relevant information shared with Advocacy.

Patient Movement Statistical Information
The Committee received and noted 2 reports during the year at its May and November 2019 meetings. The May report covered the reporting period 1 October 2018 - 31 March 2019 and the November report covered 1 April 2019 - 30 September 2019. These reports provided an overview of bed occupancy, area and source of admission, delay between referral and admission, admissions of young people (under 18), 'exceptional circumstances' admissions, appeals against excessive security, discharges and transfers and number of patients on the transfer list.

Incident Reporting and Patient Restrictions Report
The quarterly Incident Reporting and Patient Restrictions report was considered at the Clinical Governance Committee at every meeting. The report showed the type and amount of incidents received through the incident reporting system DATIX, as well as all the restrictions applied to patients during the periods under review. The report provided more information of the various incidents that had occurred in relation to PAA activations; the use of handcuffs; patient seclusions; withheld mail; urinalysis results; security incidents; communication/information incidents and incidents relating to equipment, facilities and property.

Ward Closures/Safe Staffing Report
In August 2019, due to an increase in the number of ward closures the hospital was experiencing, it was agreed that a paper would come to all Clinical Governance Committee meetings to monitor this. Papers were presented at the November 2019 and February 2020 meetings. At the November 2019 meeting it was noted there had been 2 occasions where the hospital had to use business continuity measures to support reduced staffing levels and the February 2020 paper noted 14 occasions where appropriate modifications had to be made to care delivery to ensure there was minimal or no impact to patient care.

5. Discussion Items During the Year

Two discussion items were presented during 2019/20:

Clinical Model
At the August 2019 meeting members received and noted a presentation on the Clinical Model which was delivered by the Head of Corporate Planning and Business Support, who advised that a Benefits Criteria Workshop was scheduled to take place on 21 August 2019 with a follow up Options Appraisal scheduled for 16 September 2019. The results of the options appraisal and weightings, including financial and human resource analysis were presented to the Board along with this presentation at its meeting in October 2019.

Members asked that a document detailing clear definitions be provided by the Clinical Forum in advance of the benefits criteria in order that a desk top exercise can be undertaken to ensure accurate scoring would be achieved at the options appraisal.

A further verbal update was given to the Committee in February 2020 that gave information on the broad range of consultation and feedback methods that have been used with all stakeholders both within and out with the hospital as part of this piece of work. It was also noted that 6 work streams have been introduced to work on the various areas of the Clinical Model to ensure its successful implementation. The work streams are: Workforce; Clinical Delivery; Security and Environment; Communication and Engagement; Culture, Values, Behaviour and Leadership and Finance.

Outcomes of the Implementation of the Supporting Healthy Choices Plan
At the November 2019 meeting the Chair of the Physical Health Steering Group and Lead AHP provided the Committee with a presentation on the Supporting Healthy Choices 15 point action plan. In 2016 the Clinical Governance Group supported and approved the development of the 15 point action plan but unfortunately the delivery of the plan had not improved our patients BMI. They advised that a workshop was being planned for January 2020 to discuss the results of the 15 point action plan and agree a way forward.

The presentation noted that there is evidence that patients are being admitted with higher BMI than in previous years, patients have been putting on more weight after the external purchasing was stopped and the longer a patient is with us the more weight they gain. More non-food items need to be available in the shop and assurance was given by the Skye Activity Centre Manager that this was going to be prioritised.

It was noted that some patients access the shop too often, with some patients having access up to 3 times a week; a paper was to be submitted to the Senior Management Team with a recommendation that the shop be closed at the weekends and reinvest resources into activity.

It was noted that increased BMI is an ongoing problem across society and the Group had done a great deal of work, for example, on creating the recording system for exercise. The Group intended to further review and develop ideas for addressing this.

It was agreed that feedback from the workshop in January 2020 would be given at a future meeting of the Clinical Governance Group

6. Special Topics/Items for Approval

Clinical Governance Annual Stock Take
At its May 2019 meeting, the Committee received and noted: the Clinical Governance Reporting Structures for 2019-20; the Programme of Work for 2019-20 subsequent to any changes that may arise at future meetings; the Clinical Governance Committee Terms of Reference; and the Clinical Governance Annual Report 2018-2019. The Annual Report summarised the work of the Committee during the financial year 1 April 2018 - 31 March 2019.

7. Areas of Good Practice Identified by the Committee

Research Committee Report
The Research Committee report was noted as an area of good practice with reference to research study implementation as well as inclusion of patient feedback.

CPA/MAPPA Report
100% of patients were discharged using the CPA process.

Rehabilitation Therapy Services Report
The introduction of vocational role for patients within the hospital.

Psychological Therapies Service Report
The inclusion of vignettes from patients was very well received by the Committee.

Incident Reporting and Patient Restrictions Report
The downward trend in patient assaults was noted as an area of good practice at the February 2020 meeting.

8. Matters of Concern to the Committee

Matters of concern	Update
Hand hygiene within the Skye Activity Centre	The TSH3030 project was successful in bringing around improvements with hand hygiene during November 2019. Further work will be required to ensure this improvement is sustained
Downward trend of completion of SIPSEP learning modules	There have been improvements in completion of all the SIPCEP modules within the hospital since the Infection Control 12 Monthly Report in May 2019.
Timescales for CAT 1 and Cat 2 reviews	No CAT1 or CAT 2 reviews to date
Visit Experience	A paper was presented to the February 2020 meeting with various actions that could improve the 4 main areas of concern: Visitors booking system, time taken to get carers to ward/Skye Activity Centre; creation of a dedicated visiting area and improve communication with carers

9. Conclusion

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

The State Hospital

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

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

2 COMPOSITION

2.1 Membership

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

The Chairperson of the Board, and the Chief Executive, shall both be ex-officio members.

The Clinical Governance Committee will have the authority to co-opt up to two members from outwith the Board in order to carry out its remit. These members will act in an ex-officio capacity.

An ex-officio member is a member of a body who is part of it by virtue of holding another office. Such members shall have the power to vote in the Committee's decisions. Membership will be reviewed annually.

Members:

- B Moore (from 01/02/20)
- N Johnston (Chair)
- D McConnell
- M Whitehead (until 29/02/20)

Ex-officio Members

- Terry Currie, Chairperson
- Gary Jenkins, Chief Executive

In Attendance

- Prof. Lindsay Thomson, Medical Director
- John Marshall, Head of Psychological Services
- Monica Merson, Head of Corporate Planning and Business Support
- Mark Richards, Director of Nursing & AHPs
- Robin McNaught, Finance & Performance Director
- Dr Khuram Khan, Chair, Medical Advisory Committee
- Sheila Smith, Clinical Effectiveness Team Leader

2.2 Appointment of Chair

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

2.3 Attendance

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

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

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

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

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

3 MEETINGS

3.1 Frequency

The Clinical Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.
The Chair of the Committee may convene additional meetings as necessary.
The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

3.2 Agenda and Papers

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

The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Medical Director.

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

Documents will be watermarked as Confidential or Draft as required. Documents which are watermarked as Confidential should not be shared outwith the Committee membership. Guidance on confidentiality and openness can be sought from the Records Services Manager.

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

3.3 Quorum

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

3.4 Minutes

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

Following approval, minutes will be placed on the hospital's website.

4 REMIT

4.1 Objectives

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

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

4.2 Systems and Accountability

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

4.3 Safe and Effective Care

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

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

4.4 Health, Wellbeing and Care Experience

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

4.5 Control Assurance

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

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

5 AUTHORITY

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

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

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

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Clinical Governance Committee, by presenting the minutes of the Committee.

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

8 COMMUNICATION AND LINKS

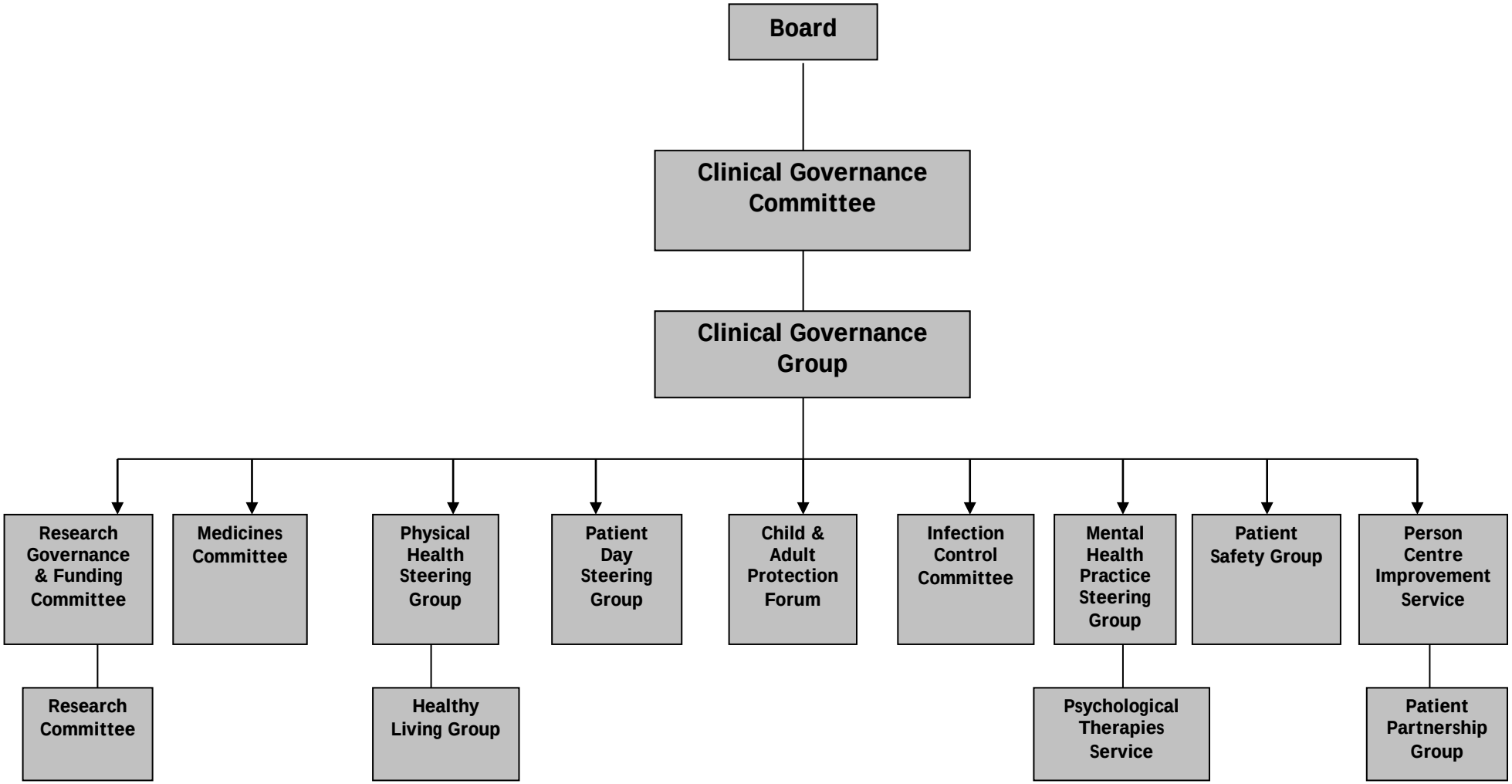
The Chair of the Committee will ensure that relevant issues are shared with the Staff Governance Committee.

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

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

Subject to annual review.
Next revision: May 2021.

ORGANISATIONAL CHART FOR CLINICAL GOVERNANCE



Clinical Governance Committee Programme of Work 2020/21

Area of review	13th February 2020	14th May 2020	13th August 2020	12th November 2020	February 2021	May 2021	August 2021	November 2021
Standing items (20 minutes)	• Minutes of last meeting • Matters arising update • NHS HIS reports as available • CIR/Adverse Event report as available • Learning from feedback • Learning from complaints • Clinical Model • Incident reporting and patient restrictions • Agreement of item for discussion at next meeting				• Minutes of last meeting • Matters arising update • NHS HIS reports as available • CIR/Adverse Event report as available • Learning from feedback • Learning from complaints • Clinical Model • Incident reporting and patient restrictions • Agreement of item for discussion at next meeting			
12 month Monitoring Reports (70 minutes)	• Psychological Therapies • Forensic Medium and High Secure Care Action Plan • Mental Health Practice Steering Group • Clinical Governance Group • Safe Staffing report	• Research Committee / Research Governance and Funding • Fitness to Practice • Patient Movement – Statistical Report • Safe Staffing report	• Rehabilitation Therapies Services • Risk Register • Patient Safety Programme • Duty of Candour • Forensic Medium and High Secure Care Action Plan • Safe Staffing report • Medicines Committee/ Pharmacy • Infection Control	• Physical Health Steering Group • Patient Movement – Statistical Report • Adult & Child Protection • CPA/MAPPA • Safe Staffing report	• Psychological Therapies • Forensic Medium and High Secure Care Action Plan • Mental Health Practice Steering Group • Clinical Governance Group • Safe Staffing report	• Medicines Committee/ Pharmacy • Research Committee / Research Governance and Funding • Fitness to Practice • Patient Movement – Statistical Report • Infection Control • Safe Staffing report	• Rehabilitation Therapies Services • Risk Register • Patient Safety Programme • Duty of Candour • Forensic Medium and High Secure Care Action Plan • Safe Staffing report	• Physical Health Steering Group • Patient Movement – Statistical Report • Adult & Child Protection • CPA/MAPPA • Safe Staffing report
Interim Reports (as required) (15 minutes)		• Covid 19						
Special topics / items for approval (15 minutes)	• Visit Experience	Clinical Governance Stock take: • Annual Report • Terms of Reference • Reporting Structures				Clinical Governance Stock take: • Annual Report • Terms of Reference • Reporting Structures		
Longer discussion items (30 minutes)	Triangle of Care (deferred)	Triangle of Care (deferred due to Covid19)	TBA	TBA	TBA	TBA	TBA	TBA

Paper No 20/29

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 June 2020
Agenda Reference:	Item No: 9
Sponsoring Director:	Director of Nursing and AHP's
Author(s):	Skye Centre Manager
Title of Report:	Skye Centre 12 Month Update Report
Purpose of Report:	Update on patient activity services within the Skye Centre

1 SITUATION

This report provides an update on patient activity services within the Skye Centre. It details service activity levels for the period 1 June 2019 to 31 May 2020.

2 BACKGROUND

This report provides an update on patient activity services within the Skye Centre. It details service activity levels for the period 1 June 2019 to 31 May 2020. Key pieces of work undertaken and future developments are also highlighted within the report. The majority of recommendations stated in last year's report have been achieved.

Over the past 12 months the dedicated, professional and flexible approach from the Skye Centre staff group has enabled them to continue delivering a quality service to our patients. The Skye Centre closed at the end of March 2020 in response to the COVID-19 pandemic. During this time the Skye Centre staff have been instrumental in supporting the wider hospital and have provided daily escorted walks for patients to support them during this difficult time. Staff volunteered to change their working pattern to ensure this level of activity is offered over 7 days, and which has had a positive impact on the lives of our patients.

3 ASSESSMENT

Key Pieces of Work Undertaken During the Year

- Patient Active Day
- Patient Timetable
- Vocational Qualifications/Course
- Events

Identified Issues and Potential Solutions

- Recruitment
- Sickness

4 RECOMMENDATION

The Board are requested to consider the content of the report and the future areas of work recommended for the next 12 months.

Future Areas of Work and Potential Service Developments

- Patient Day Project
- Skye Centre Induction Pathways
- Provision of Activity Out With 9-5

- Patient Timetable
- Outcome Measures
- COVID19 Restrictions
- Efficiency Savings Targets

MONITORING FORM	
How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports the KPI's related to patient activity
Workforce Implications	Considered under section 5
Financial Implications	None
Route To SMT Which groups were involved in contributing to the paper and recommendations.	Clinical Governance Group
Risk Assessment (Outline any significant risks and associated mitigation)	None
Assessment of Impact on Stakeholder Experience	Risk of not delivering appropriate access to services
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 HOSPITAL BOARD FOR SCOTLAND

SKYE CENTRE

12 MONTH UPDATE BOARD REPORT

1 June 2019 – 31 May 2020

Reference Number		Issue:
Lead Author	Jacqueline Garrity, Skye Centre Manager	
Contributing Authors	Tracy Tait, Skye Centre Secretary	
Approval Group	The State Hospital Board	
Effective Date	1 June 2019	
Approval Date		
Responsible Officer (e.g. SMT lead)	Mark Richards, Nursing & AHP Director	

Contents

Section 1 – Introduction

This report provides an update on patient activity services within the Skye Centre. It details service activity levels for the period 1 June 2019 to 31 May 2020. Key pieces of work undertaken and future developments are also highlighted within the report. The majority of recommendations stated in last year's report have been achieved.

Over the past 12 months the dedicated, professional and flexible approach from the Skye Centre staff group has enabled them to continue delivering a quality service to our patients. The Skye Centre closed at the end of March 2020 in response to the COVID-19 pandemic. During this time the Skye Centre staff have been instrumental in supporting the wider hospital and have provided daily escorted walks for patients to support them during this difficult time. Staff volunteered to change their working pattern to ensure this level of activity is offered over 7 days, and which has had a positive impact on the lives of our patients.

2019/20 Recommendations Update - Comparison with last year's report

Recommendation Description	Achieved/Not Achieved	Comments
Outcome Measures – The initial work carried by the Specialist OT will be embedded across the service and planned focussed work related to the completed patient interest checklists will support the future development of new and appropriate activities.	Achieved	Outcomes measures are integrated into the Skye Centre induction processes and have informed person centred approaches for individual patients across the Activity Centres. The outcome of these assessments supports the OT to communicate the focus of their work in improving occupational function with patients and the communicating the outcomes to the wider multidisciplinary team.
Patient Timetable The format of the patient timetable has been developed and the pilot has been concluded. The Pilot will be reviewed and the system will be implemented across the site.	Achieved	The timetable was rolled out to the remaining three Hubs on 9th March 2020 with an expected date of completion being 1st April 2020. The enhanced measures related to Covid-19 in March 2020 delayed this process however as of mid-April the RIO timetable has been successfully used across all Hubs and Skye Centre
Vocational Activity Space – The Vocational Activity room can be available to be booked for individual or group activities by a range of disciplines.	Achieved	The Vocational space is used mainly by the AHP staff for 1:1 and group activity. PCIT use as and when required.
Patient Day Project The Patient Day Steering Group has agreed that further evaluation of the Patient Day Model will be carried out. The focus will be on the Iona 3 patient group, taking into consideration feedback from these patients and their lack of engagement in planned structured activities whilst at the Skye Centre.	Partially Achieved	Further feedback was obtained from both patients and staff in July 2019. Both groups were asked for their views and their experience of the project since January 2019. The initiative involving Iona 3 patient group was not progressed due to the gap in SCN within this area and the impending review of the Clinical Model. Work in this area has been paused due to COVID-19
Provision of Activity out with 9 – 5 – The patient group have requested more activity out with business hours of 9 – 5.	Not achieved	Pilot to provide weekend activity was approved by the SMT and proposed to commence in April 2020. This has been postponed as the Skye Centre has been closed due to COVID-19contingency plans.

Overview
The Skye Centre service is defined by four Activity Centres (Patient Learning, Sport & Fitness, Craft & Design, and Gardens & Animal Assisted Therapy) and also includes the Atrium where the patients can access the activity group room, café, library, shop and bank. There are also a variety of other groups facilitated in this environment by the Person Centre Improvement Team, (Patient Partnership Group, Christian Fellowship and Multi Faith Services), the Psychological Therapies Service and Allied Health Professions staff. It is also important to note that the Health Centre is an integral part of the service and operates closely with the wider activity centres and Atrium.

Service Delivery
Staff configuration
The Skye Centre service consists of a group of registered Nursing staff, and a Specialist Occupational Therapist who are supported by skilled technical staff and Health Care Support Workers. Each staff member is dedicated to meeting the clinical, educational, health & wellbeing, vocational and recreational needs of our patient population.

The Skye Centre staffing establishment is presently 38.33 wte, the actual staff in post is 35.83 wte due to vacancies. The service is currently operating with 3 vacancies (2.5wte) created due to retirement and promotion. The recruitment for these posts was ongoing and at various stages in the process however as a result of Covid-19 restrictions this has been postponed. Prior to this, adjustments were made to internal staff deployment across the service to mitigate against the temporary loss of these posts.

Volunteers
The Skye Centre service continues to work alongside the Person Centred Improvement Team (PCIT) to support the role of volunteers across the service. There are currently 7 volunteers supporting activity across the activity centres each have 1 dedicated session – morning or afternoon. There are 3 for the PLC, 1 for Sports, 1 for the Gardens, 1 for the Patient Library and 1 for the Shop/Café area. At present their input has been temporarily suspended due to Covid-19.

The Skye Centre service operates Monday to Friday with sessions available morning and afternoon, with reduced activity also available on a Saturday and Sunday - Skye Centre staff continue to be supported by Hub based nursing staff to provide weekend activities

Delivery of Interventions
There are a wide range of group interventions available to the patient group attending the Skye Centre. The range of groups on offer are defined under the following categories, these are:-

- Crafts & Creative Expression
- Education & Learning
- Life Skills
- Physical Health & Fitness
- Recreation
- Mental Health & Recovery
- Vocational & Work Activities

The interventions are available at varying degrees of complexity to meet our patient needs and are delivered in a variety of formats. There are regular ongoing group activities such as crafts or sports and general learning sessions for which there is no restricted time limit. The scope of these activities will be modified depending on the needs of the patients participating. In contrast to this there are a number of planned, time limited groups such as Skye Centre Induction or SVQ qualifications i.e. Sports Leadership, Creative Arts. Patients are approved to participate in these group activities after discussion with their respective Clinical Teams. The Skye Centre staff have also worked jointly with the Music Therapist to deliver the Community Choir, held in the Vocational Activity room.

Section 2 - Governance & Management Arrangements

Governance Arrangements

Formal update reports on Skye Centre activity are reported on an annual basis to The State Hospital Board and the service is represented at this group by the Nursing & AHP Director. Strategic aims and priorities for Skye Centre activity levels are monitored on an ongoing basis by the Skye Centre Manager who reports to the Clinical Operations Manager. Approval for new developments and initiatives are discussed and generated through the Skye Centre Leadership Group and are further approved by the Senior Management Team at which the Skye Centre service is represented. Performance data related to the Skye Centre is also reported to the Clinical Governance Group on a quarterly basis.

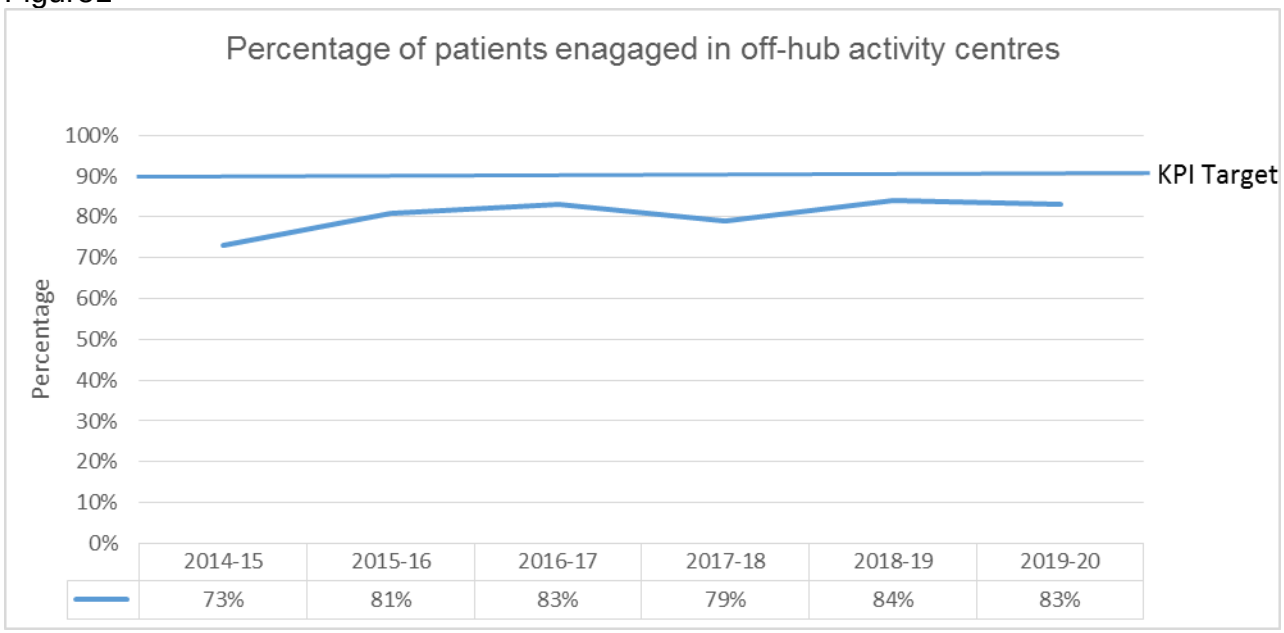
Management Arrangements

The Skye Centre Manager is operationally responsible for the Skye Centre service and staff group. The Senior Charge Nurse is managerially responsible for the group of nursing staff, Senior Occupational Therapist and support staff group. There are 4 (1 acting) Charge Nurse posts across the service each with responsibility for the day to day supervision of discrete areas of the service.

Section 3 - Key Performance Indicators

The performance target that relates to the Skye Centre is that 90% of patients will be engaged in off-hub activity centres. Figure 1 below provides an overview of Skye Centre performance in relation to this target. The Skye Centre closed on 23 March 2020 in response to the enhanced measures related to the Interim Operational Policy put in place in response to the COVID19 pandemic. Data is not available from 23 March to 31 May 2020.

Figure1



The performance indicators are underpinned by a number of supporting measures, including:

- Provision of reports for annual review meetings
- Patient Learning Outcomes
- Standardised Assessment Tools
- Attendance at clinical supervision

Safe

Table 1 below provides an overview of the total number of incidents occurring within the Skye Centre over the past 12 months. There has been a decrease in the overall number of incidents reported involving the Skye Centre from 98 to 45. The number of Health & Safety incidents decreased from 50 to 20. The number of slip/trip/falls have reduced and were previously attributed to one patient. The number of incidents related to Staff/Patient Injury have reduced; there have been less incidents recorded that have been related to injuries sustained in the Sports & Fitness for both staff and patients. The number of Security incidents decreased from 37 to 18. This can be attributed to the previous issue related to PMTS user error at Hub/reception level during the booking out process for patients which has been resolved.

The delivery of activities continues to be risk assessed and modified to ensure that patients have access to the necessary resources, tools and equipment at a level appropriate to their needs.

Table 1: Total number of incidents occurring within the Skye Centre 1 June 2019 To 31 May 2020. Broken down into Category Types

Incident Category	**1 Jun 2019 - 31 May 2020**	**1 Jun 2018 - 31 May 2019**	**1 Jun 2017 - 31 May 2018**	**1 Jun 2016 - 31 May 2017**
Health & Safety				
Assault	2	2	2	3
Attempted Assault	2	1	3	3
Behaviour	4	8	12	18
Sexual	0	4	2	4
Verbal aggression/abuse	1	4	12	9
Struck	0	0	3	2
Staff/Patient Injury	2	16	12	19
Slip/Trip/Fall - Patient	4	11	10	12
Slip/Trip/Fall - Staff/Other	2	1	1	1
Moving & Handling	1	0	0	1
Fire Alarm Activation	1	1	0	0
Injured by animal	1	2	0	3
Staff Resource Issue	0	0	0	5
	20	**50**	**57**	**80**
Incident Category	**1 Jun 2019 - 31 May 2020**	**1 Jun 2018 - 31 May 2019**	**1 Jun 2017 - 31 May 2018**	**1 Jun 2016 - 31 May 2017**
Security				
Breaches	11	5	10	14
Control of Patient Whereabouts	2	25	0	0
Prohibited/Res Items	2	1	0	0
Keys	1	0	2	1
Other	2	6	6	10
	18	**37**	**18**	**25**

Table 1 cont/

Communication/Information Governance				
Breach of Patient Confidentiality	1	2	1	3
Breach of Staff Confidentiality	0	0	1	0
Communication Breakdown	1	3	0	0
Documentation	1	0	0	0
	3	**5**	**2**	**3**
Equipment/Facilities/Property				
Equipment Malfunction	2	3	3	5
Theft	0	2	0	0
Contact	1	0	3	6
Damage	0	0	0	2
	3	**5**	**6**	**13**
Infection Control				
Exposure	1	0	0	2
Laundry	0	1	0	0
	1	**1**	**0**	**2**
Totals	**45**	**98**	**86**	**123**

Effective
The progress of individual patients is monitored in a number of ways. This can be achieved subjectively using non-standardised methods such as observation of behaviours, interactions with peers/staff and the recording of staff clinical reasoning and judgement, documented using the electronic patient record (RIO).

Outcome Measures
The Specialist Occupational Therapist post was introduced to the Skye Centre service in February 2019 and is an integral member of the Skye Centre staff group. They have identified and embedded a range of standardised assessment tools using these as and when these are clinically required, to support the assessment and treatment process available to our patients across the service.

The number of MOHOST assessments completed have increased from 3 to 60. This assessment is based upon concepts of the model of human occupation which addresses motivation, performance and the organisation of occupational behaviour in everyday life. The MOHOST as a screening tool enables the clinician to evidence their clinical reasoning in assessing a person, their skills and capabilities within their environment. The MOHOST not only supports the OT to communicate the focus of their work in improving occupational function with patients and the wider multidisciplinary team it also evidences how Occupational Therapy practice brings change to people's lives. The Specialist OT has stated that:

"In moving the focus of my work to the Skye Centre, I have found greater insights into the impact of this setting on patients function and have had the opportunity to explore more avenues for rehabilitation for patients"

The range of assessments that have been carried out since this individual has taken up post are detailed in Table 2 below:

Table 2

Outcome Measure	June 2019 – March 2020	Feb 2019 – May 2019
MOHOST	60	3
Volitional Questionnaire	23	10
OCAIRS	1	1
Interest Checklist	-	5
AMPS	1	-
OSA	6	-
ACIS	3	-
AOF	1	-
WRI	3	-
Allen Cognitive Level Screen	-	3
Peavy social comportment	-	2
Total	98	24

There is also a range of Patient Learning Outcomes and KPIs in place across the service and these are reported annually in a separate report to the Board. This report was received in April 2020 and detailed the progress made and the recommendations related to patient learning for the coming year. It is important to note that these outcomes related to patient learning are an integral part of the Activity Centres and support the selection and development of the patient timetable.

Skye Centre staff do not routinely attend weekly Clinical Team meetings and Annual CPA Review meetings however every effort is made to ensure staff input is available as and when the clinical need is indicated.

During the period of the report there were 85 annual reviews and the Skye Centre VAT form completion was 100%. Table 3 below outlines the ICP data for the previous 2 years.

Table 3 Skye Centre ICP DATA

	June 2019 - May 2020	June 18 - May 2019	June 17 - May 2018
Treatment and Rehabilitation VAT	n=85	n=94	n=100
Skye Centre report available	81.2% (69)	65% (61)	72% (72)
Those not done			
Case Review date changed		2	1
No reason	1		1
No SAC placements	13	26	25
Patient unsettled presentation			1
Staff sick leave		3	
Staff not aware of review		1	
Not done prior to Case Review		1	
COVID Restrictions	1		
VAT form not completed	1		
SAC Rep discuss content of report with patient prior to Case Review	n=85	n=94 (59)	
Those not done	65.9% (56)		
Case Review date changed		2	
No reason	1	1	
No SAC placements	14	26	
Staff not aware of review		1	
Not done prior to Case Review		1	
Patient unsettled presentation		1	

Staff sick leave		3	
COVID Restrictions	13		
VAT form not completed	1		

Admission VAT	**n=18**	**n=22**	**n=22**
Admission Fitness Assessment completed	88.9% (16)	81.8% (18)	45.5% (10)
Joint Admission/Discharge CPA			
No Reason			2
Patient unsettled presentation			3
Not referred by CTM		2	6
Not required as Re-admission			1
COVID-19 Restrictions	2		
	n=31	n=32	
Skye Centre Induction Report	48.4%(15)	37.5% (12)	
Those not done			
No outstanding need		1	
No reason	1	4	
Not referred by CTM	1	1	
Not required as re-admission		2	
Patient declines		1	
Patient unsettled presentation	2	3	
Staffing issues		3	
Still in progress	3	5	
COVID-19 Restrictions	8		
Exceptional Circumstances Admission	1		
Day of Discharge	**n=25**	**n=32**	**n=31**
SAC Patient Learning Report	52% (13)	37.5% (12)	45.2% (14)
Those not done			
Discharge to court	1	6	3
No reason		8	6
No SAC placements	6	2	6
Patient transferred overseas			1
Not applicable			1
Not necessary for prison transfer		1	
Administrative Error		1	
No outstanding need	1	1	
Staff not aware of review	2	1	
Licence revoked	1		
Professional Report not received	1		

SAC Activity Centre Report	52% (13)	37.5% (12)	45.2% (14)
Those not done			
Discharge to court	1	6	3
No reason	1	8	6
No SAC placements	6	2	6
Patient transferred overseas			1
Not applicable			1
Not necessary for prison transfer		1	
Administrative Error		1	
No outstanding need	1	1	
Staff not aware of review	2	1	
Licence revoked	1		

Due to COVID-19 restrictions the Skye Centre has been closed therefore face to face discussion regarding annual report outcomes have not taken place and the Skye Centre Induction process has been temporarily suspended for new admission patients.

Person – Centred
The Skye Centre service continues to comply with the principles outlined in the revised NHS Complaints & Feedback Procedure and staff are encouraged to act on all feedback effectively, resolving issues as early as we can and learning from them where we can so that we can improve our service.

There has been a decrease in the number of complaints from patients and carers regarding the Skye Centre within the last 12 months. Table 4 below outlines the number of complaints received during the reporting period. A total of 9 complaints were received (2 upheld, 1 partially upheld, 5 not upheld, 1 withdrawn) in comparison to 15 during the previous year (8 upheld, 1 partially upheld, 4 not upheld, 2 withdrawn). Appendix 1 provides further detail for each complaint.

Table 4

Skye Centre Complaints	**1 June 2019 - 31 May 2020**	**1 June 2018 - 31 May 2019**	**1 June 2017 - 31 May 2018**
Stage 1 Complaint	8	8	6
Stage 2 Complaint	-	5	3
Escalated to Stage 2	-	-	-
Withdrawn	1	2	2
Total	**9**	**15**	**11**

In previous years a number of complaints have been received from patients regarding access to services and centre closures. There were 6 complaints received in relation to this over the past year, a decrease from 9 received during 2018/2019. Included in this total 2 complaints were related to access to services which were upheld and 1 was partially upheld.

Figure 2 provides a summary of the last 10 months planned sessions in comparison to the actual sessions attended. The Skye Centre closed on 23rd March 2020 due to COVID-19 and this impacted on the number of actual sessions attended by patients. There was also a reduction in the number of sessions attended over the 2 week period prior to the centre closing due to the gradual introduction of the enhanced measures related to COVID19. The total number of sessions not attended due to COVID19 restrictions during the period 23 March 2020 to 31 May 2020 data is **4830**

Figure 2

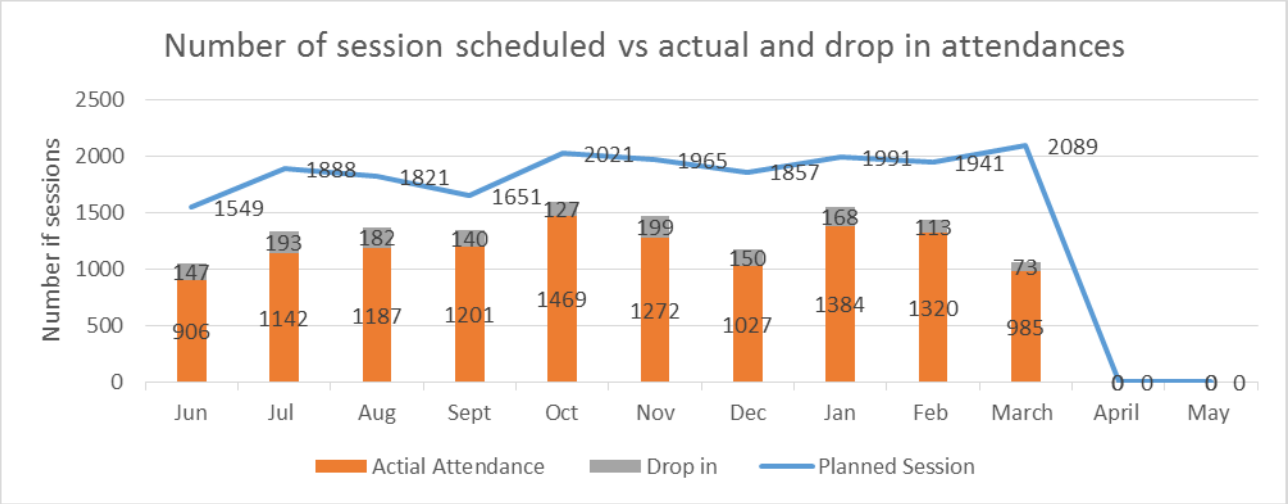


Table 5 below provides details of the number of planned sessions over the past 5 years in comparison to the actual number of sessions attended. As previously noted the Skye Centre closed on 23rd March 2020 due to COVID-19 therefore the data available in Table 5 for 2019/20 relates to planned sessions and actual attendances up to 20 March 2020.

Table 5

	Planned Sessions	**Number of actual attendances**	**%between planned and actual**
2019/20	**18773**	**11893**	**36%**
2018/19	21359	13793	35%
2017/18	19187	12089	37%
2016/17	20853	13703	34%
2015/16	24032	19076	21%

The reasons for non-attendance over the past 12 months are detailed in Table 6 below.
The 2019/20 data included in the table relates to the period 1 June 2019 to 20 March 2020 as the Skye Centre has been closed from 23 March 2020. During the period that the Skye Centre has been closed has resulted in **4830** planned sessions being cancelled.

The figures related to Mental Health have continued to rise over the past 5 years to 750 from 578 in 2015/16. This correlates to with the increase figures related to Patients declining to attend which has also continued to rise to 802 form 481 in 2015/16.

Non attendance due to patients attending appointments with other clinicians has continued to rise from 429 in 2015/16 to 700. It is anticipated that the introduction of the RIO patient timetable will address this matter.

Table 6 Reasons for non-attendance at planned sessions

Reasons for non-attendance at Planned sessions	2019/20*	2018/19	2017/18	2016/17	2015/16
Closures (unplanned - staffing, sickness or skill mix up until March 2020)	2205	2349	2368	2565	1511
Closures (staff deployment to wards/outing to cover nursing deficits	0	332	n/a	n/a	n/a
Closures Inclement Weather	199	189	637	200	45
Closure (Planned - Skye Centre events)	200	145	n/a	n/a	n/a
Reduced patient numbers incl COVID19	480	497	n/a	n/a	n/a
Deterioration in Mental Health	750	717	652	640	578
Physical Health Problem	483	441	479	620	518
Appointments with other Health Care Professional	700	620	589	586	429
External appointments	50	121	133	320	500
Tribunal/CMT/CPA Appointments	20	32	40	51	58
Patients Declined to attend schedule session	802	709	751	698	481
Patient seeing external visitor	50	47	30	50	79
Visit on ward	200	282	211	350	109
Discharge/Transfer/rescheduled sessions	142	327	249	277	219
Attending other Skye Centre activities using Drop in	299	265	173	293	75
Other	300	488	786	500	354
Total	**6880**	**7596**	**7098**	**7150**	**4956**

***Data provided for the period 1 June 2019 – 20 March 2020**

Referrals

Referrals are received from the CTM for patients to attend a range of activities provided by the Skye Activity Centres. Table 7 below provides the referral data for the previous 5 year reporting period. There has continued to be a downward trend of the number of referrals received by the service. The introduction of the Skye Centre Induction Pathways has influenced this as patients attend these sessions without a referral being made by the CTM. There has also been no referrals received since the end of March due to the COVID19 restrictions. In comparison to previous months it is not considered that the number of referrals that would have been received during this timeframe would have been sufficient to influence the downward trend.

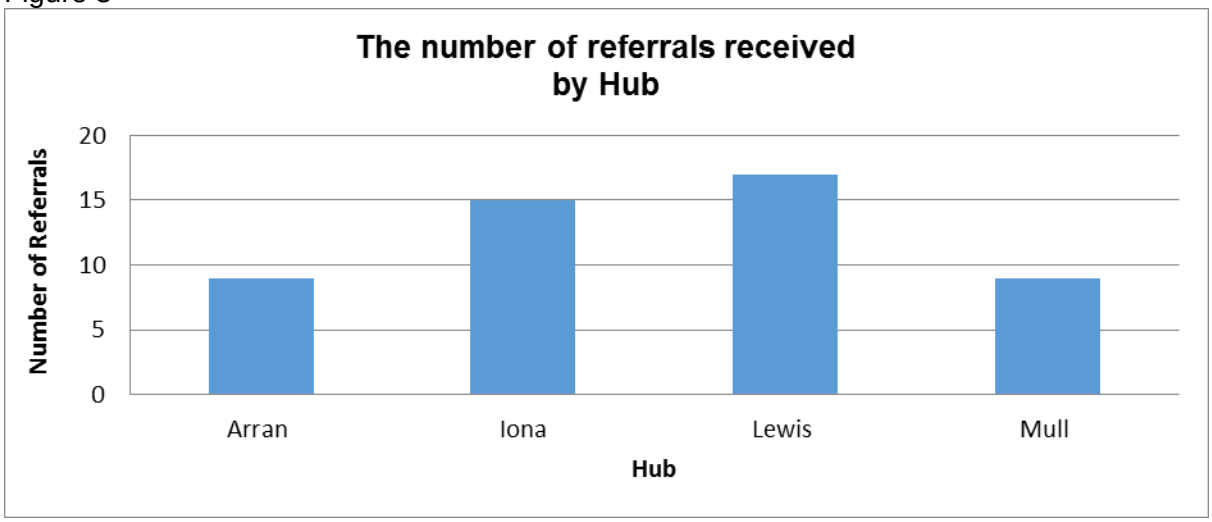
Table 7 Number of Referrals

	No. of referrals received	No of Patients
2019/20**	50	31
2018/19	85	45
2017/18	93	61
2016/17	170	117
2015/16	136	58

****** due to COVID-19 restrictions no referrals have been processed since 23 March 2020.**

Figure 3 below provides the number of referrals received from each hub following discussion and approval from the respective Clinical Teams.

Figure 3



Skye Centre Induction Pathways

During the period June 2019 to May 2020 data was available for 18 new admission patients. 11 patients have not received their induction due to the COVID-19 restrictions introduced on the 30th March 2020, 1 patient's physical health remains too poor to complete the induction and 2 patients were discharged before the induction was completed.

Figure4

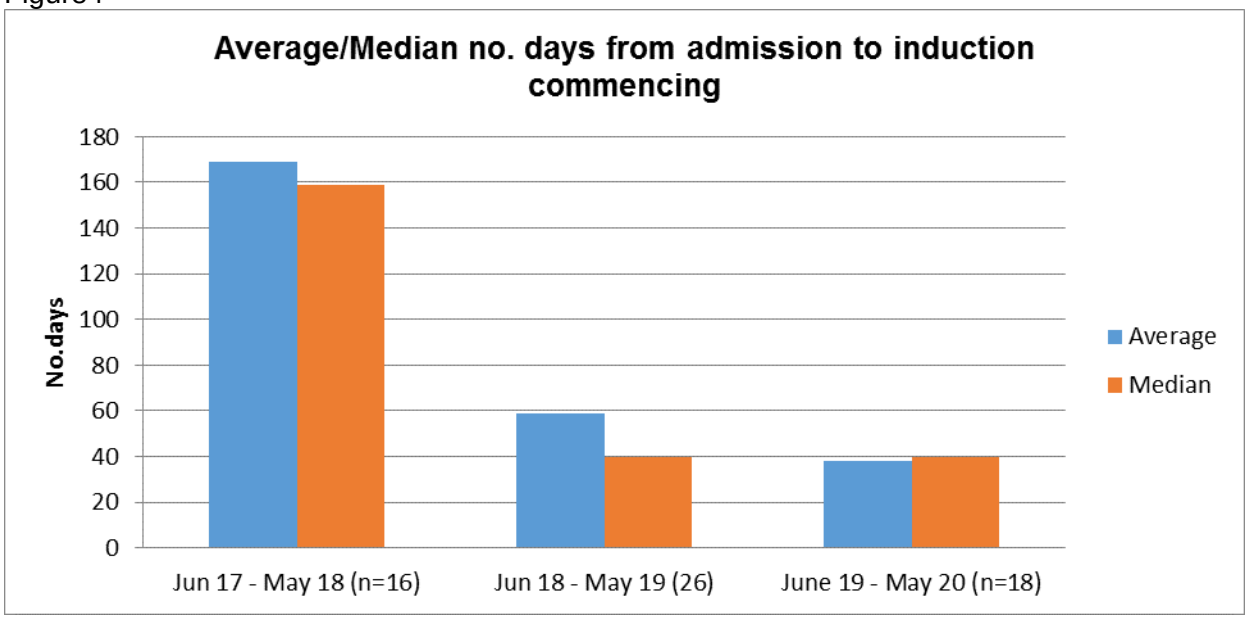


Figure 4 continues to show a decrease related to the average number of days from admission till patients commencing the Skye Centre induction.

Figure 5 provides more detail regarding the number of days from admission till patients commence the Skye Centre Induction

Figure 5

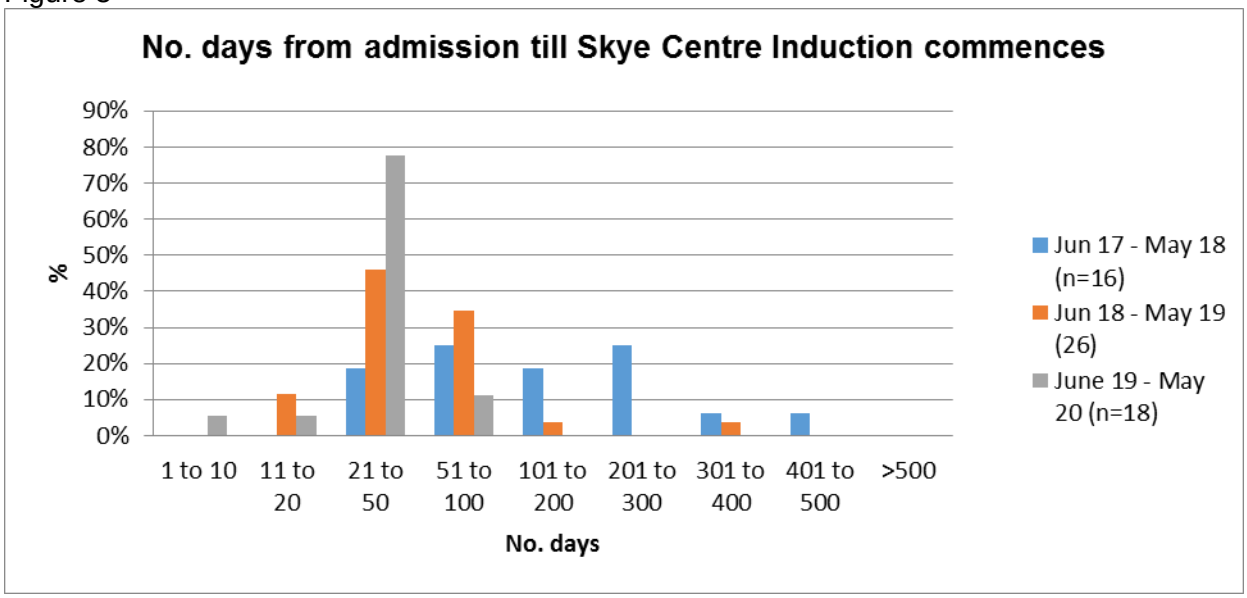


Figure 5 shows the number of days from admission until patients receive their Skye Centre induction. This has continued to decrease with no patients waiting over 100 days to attend the induction. 77% of admitted patients received their Skye Centre Induction between 21 to 50 days following admission 6% of admitted patients commenced the induction between days 1-10.

Figure 6 details both the average and median number of days from admission till patients receive their Hub Fitness induction. There continues to be a decrease in the average number of days from admission till patients receive their induction by Sports and Fitness Staff.

Figure 6

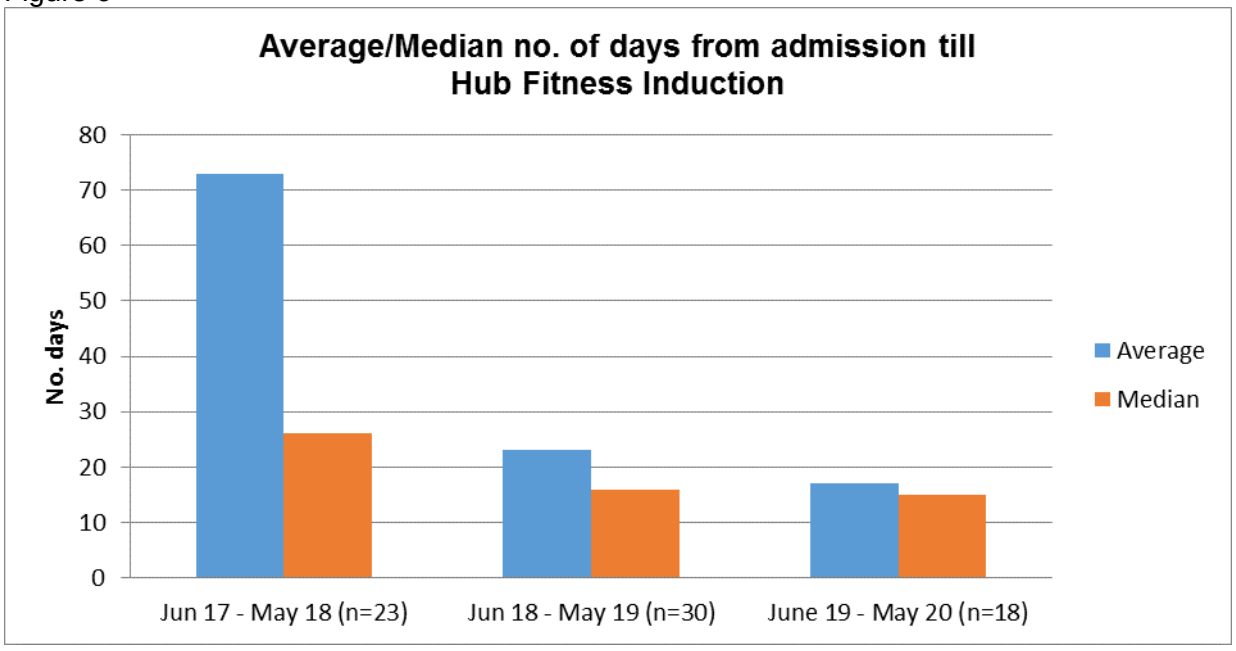
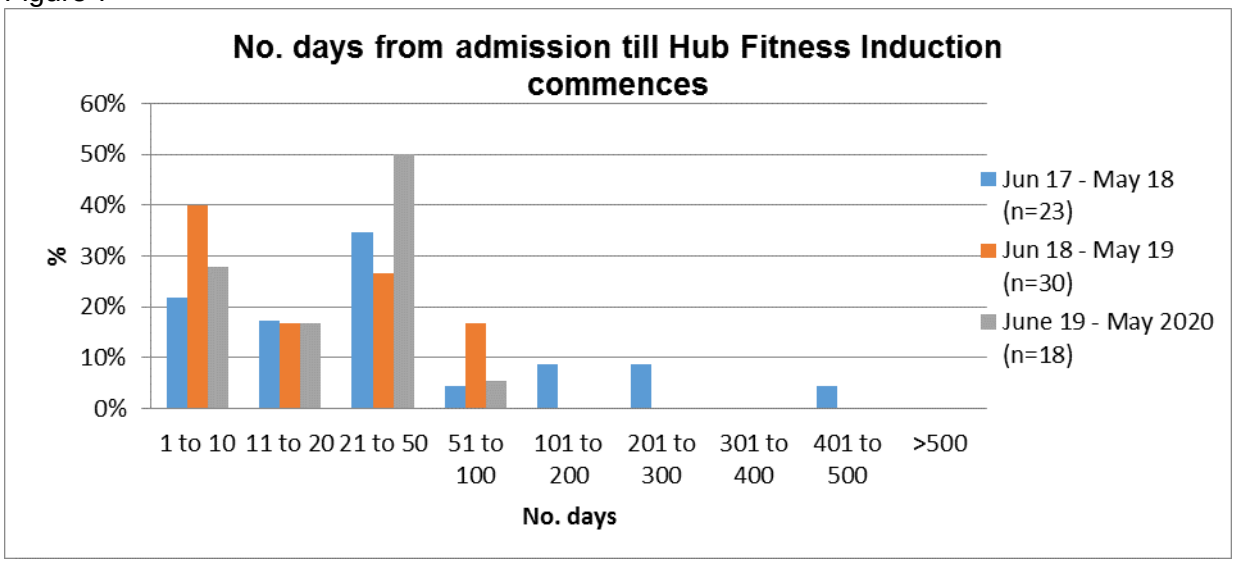


Figure 7



As defined in the Induction pathway the Sports and Fitness staff contact wards no later than two days following admission to arrange for staff to visit newly admitted patients on ward to complete Hub Fitness Induction. Over the past 12 months 50% of newly admitted patients have completed their Induction within 21 to 50 days.

As defined in the Induction Pathway the Sports and Fitness staff aim to commence the next stage of the induction within 21 days of admission following Clinical Team approval. Once patients have received their induction to the Sports and Fitness department they are allocated 2 x 45 minute admission sessions.

From the period June 2019 up until the restrictions were applied for COVID-19 in March 2020 the Sports and Fitness department met the target for initiating contact within two days of admission to arrange patient inductions.

Figure 8

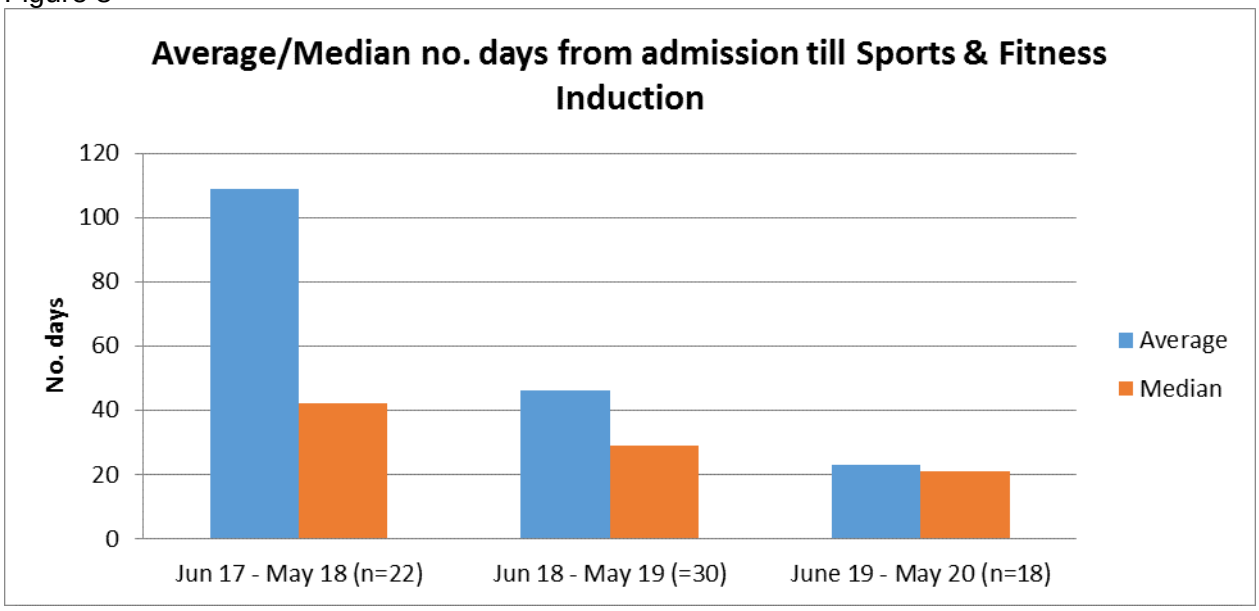
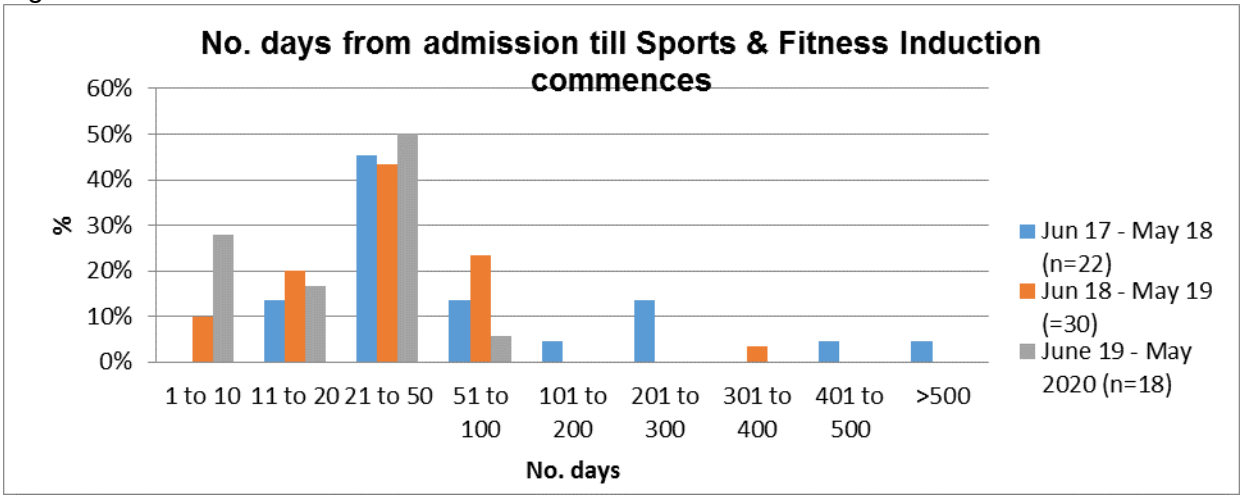


Figure 8 continues to show a decrease in the average number of days from admission till patients complete the Sports and Fitness Induction and commence their two allocated 45 minutes session each week.

Figure 9



The number of days from admission till patients receive their Sport & Fitness Induction has continued to decrease over the past 12 months with no patients waiting over 100 days to attend the induction. The reason for 5% (n=2) of admitted patients waiting between 51-100 days was due to awaiting Clinical Team approval for the patients to attend. 50% of admitted patients received their Sports induction between 21 to 50 days following admission. Although this is above the Pathway target for access to Sports & Fitness there has been a steady increase over the last two years in the number of patients able to complete the induction between 1- to 10 days following admission.

There are 93 patients (84%) with planned activity sessions at the Skye Centre (data related to week commencing 16th March 2020). This is in comparison to 91 patients (84%) in 2019.

The patient engagement can range between 1 session and 10 sessions. Many patients attend more than one activity centre and they may be involved in individual tasks or participate in group projects.

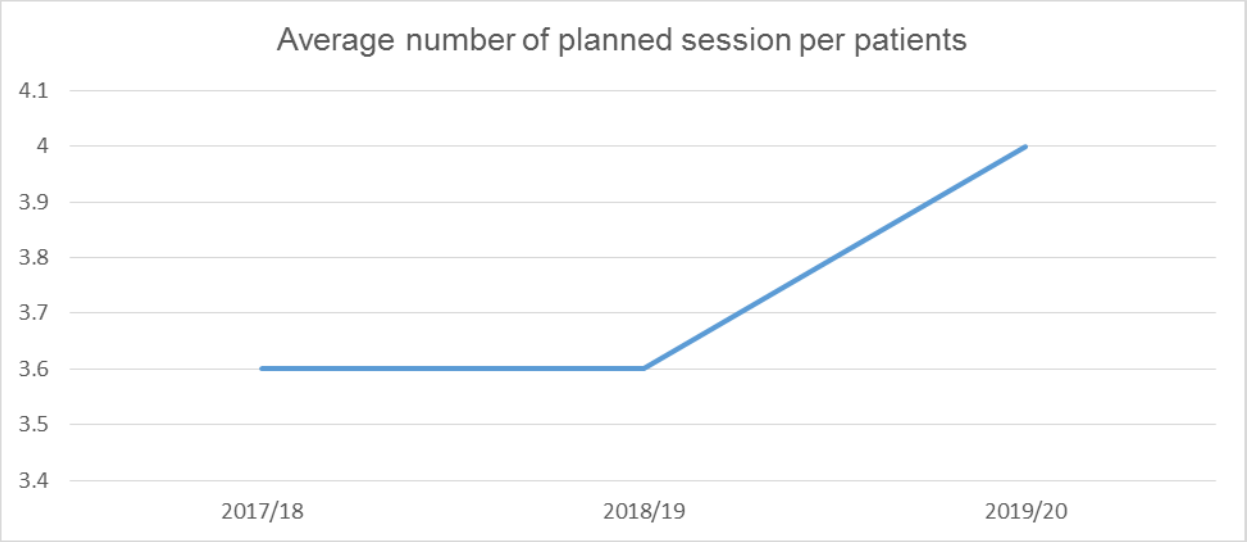
Number of Planned sessions	**Arran**			**Iona**			**Lewis**			**Mull**			**Total**		
	19/ 20	*18/ 19*	*17/ 18*	*19/ 20*	*18/ 19*	*17/ 18*	*19/ 20*	*18/ 19*	*17/ 18*	*19/ 20*	*18/ 19*	*17/ 18*	*19/ 20*	*18/ 19*	*17/ 18*
Patients	***24***	***21***	***21***	***31***	***32***	***30***	***35***	***33***	***33***	***21***	***21***	***23***	***111***	***107***	***107***
0	5	6	6	7	6	10	4	4	4	2	2	3	***18***	***18***	***23***
1	0	1	3	1	2	1	2	1	2	2	1	2	***5***	***5***	***8***
2	4	2	1	4	9	7	5	8	3	0	3	4	***13***	***22***	***15***
3	4	5	4	5	6	3	6	4	2	3	3	1	***18***	***18***	***10***
4	2	2	1	6	4	4	3	5	4	3	2	1	***14***	***13***	***10***
5	1	2	1	3	2	1	3	3	7	2	3	3	***9***	***10***	***12***
6	3	0	1	0	0	2	5	2	3	3	0	4	***11***	***2***	***10***
7	2	0	2	2	1	0	1	2	3	1	2	3	***6***	***5***	***8***
8	1	2	1	1	2	2	3	2	2	3	2	0	***8***	***8***	***5***
9	1	1	1	2	0	0	1	1	1	1	3	1	***5***	***5***	***3***
10	1	1	0	0	0	0	2	1	2	1	0	1	***4***	***2***	***3***

Table 8

Table 8 demonstrates the number of planned sessions that individual patients are allocated (data related to week commencing 23rd March 2020). It is evident that each hub varies in relation to individual patient engagement at the Skye Centre. The data presented is reflective of the patients' weekly Skye Centre timetable across each of the Activity Centres however it is important to note that patients also access the Skye Centre for a variety of other activities during the week. The majority of patients attend the Patient Shop one morning per week and choose to use the facilities in the café and library area. There were 1492 Drop Ins during the period 1 June 2019 to 22 March 2020 which are not reflected in table 8. The Skye Centre is also accessed by other disciplines for 1:1 and group activity which is not reflected in the table above and data is recorded separately i.e. Person Centre Improvement Team, Psychology, AHP

Over the past 12 months patients have on average 4 planned sessions. (Figure 10)

Figure 10 – Average Number of Skye Centre Sessions



"What Matters to You' Campaign: 6th June 2019

The Skye Centre team, supported by the Person Centred Improvement Team, facilitated the 'What Matters to You?' event on the afternoon of 6 June 2019. The event was held in the Sports Centre and patients attended with staff and Volunteers. Tables with prepared posters were arranged by activity area to allow patients to comment on each area in turn; they were asked to highlight 'what matters most' about an area, 'how could we make it better', and then select 'three things we've agreed to do in the next 12 months'.

The group reflected on these two questions in relation to each activity area, from which a focused discussion took place, following which the Skye Centre "What Matters to You' Action Plan was devised. (Appendix 2). This action plan has helped inform service developments and informed practical changes within individual activity areas e.g. themed 1 day workshops in Crafts, deliver a minimum of two evening social events, reduce noise levels in the PLC (certain sessions).

Patients with significant barriers to communication were supported to share their views, eliciting some insightful comments.

Section 4 – Key Pieces of Work Undertaken During the Year

Patient Day Project

The Patient Day Project continued to be delivered across all 4 hubs. Each identified ward has 2 allocated sessions across the week with Lewis 2 being the only ward to attend both sessions on the same day.

The working assumption underpinning the Patient Day model, is that a ward closes for a morning or afternoon session, and the patients from that ward spend their time within the Skye Centre. In doing so, more patients from that ward will have the opportunity to access structured activity sessions, on a regular basis.

Further feedback regarding the project was obtained from both patients and staff in July 2019. Both groups were asked for their views and their experience of the project since January 2019. The Person Centred Improvement Team provided an Emotional Touch Point detailing feedback from our patients and the staff groups were asked to answer the following 3 questions:-

1. What has worked well for you when you have attended the Patient Day allocated session times?
2. Please tell us about anything you have found difficult whilst working during your ward's allocated session times.
3. If we could make one change to improve your experience, what would it be?

Several themes emerged from the patient and staff feedback (Appendix 3 & 4) and an action plan (Appendix 5) was devised which incorporates these. The themes are highlighted below.

- Clarity regarding the role of ward nursing staff attending the Skye Centre to support the project and the expectations placed on ward staff to support the Skye Activity Centres.
- The availability and choice of activities on offer to patients attending the Atrium.
- Operational challenges experienced by both ward and Skye Centre staff to ensure that the patients attend in a timely and safe manner.
- Access to activity spaces/interview rooms in the Atrium area for both patients and staff.

Updates on the progress of the Patient Day project are provided quarterly to the Clinical Governance Group. The model will be extended further in line with the Clinical Model review.

Patient Timetable

The RIO timetable pilot was successfully implemented and used daily by Lewis ward Nursing staff, Skye Centre and AHP staff. The timetable was rolled out to the remaining three Hubs on 9th March 2020 with an expected date of completion being 1st April 2020. The implementation of enhanced measures related to Covid-19 in March 2020 delayed this process however as of mid-April the RIO timetable has been successfully used to record our current level of patient activity across all wards, Skye Centre and wider disciplines. Daily reports are able to be provided and weekly reports are provided to the Interim Operational Policy Monitoring Group. The Clinical Governance Group is scheduled to meet on 24th June and the future governance of the reporting methods for the patient timetable and the data provided will be determined at this meeting.

Vocational Qualifications/Courses

Patient learning programmes are an integral part of the Skye Centre service with our Senior Rehabilitation Instructors and Education & Learning Officers responsible for the delivery of patient learning programmes. The objectives and progress made in this area over the past year are outlined in more detail within the recent Patient Learning 12 month Update report to the Board presented in April 2020.

The Craft & Design department successfully delivered the National 2 Practical Crafts qualification (with 8 patients achieving the qualification) plus a new National 2 Creative Arts programme that was developed and approved in 2018. Introduction of the Creative Arts programme allows patients

attending the department to extend their knowledge across two different introductory courses and both are accessible to all patients during tooled and low-tooled session. In addition, the department developed and gained approval to deliver the SQA National 3 and National 4 Art and Design qualifications. The new programme at National 3 will be piloted in 2020 and provides learners with a further progression pathway.

During 2019, the Gardens department updated the 'Feeding and Watering of Small Animals' qualification in conjunction with internal verification support from Dundee & Angus College. This programme had not been delivered since 2016 due to resource and capacity issues within the department and was reintroduced and successfully delivered at the end of 2019 (with 6 patients achieving the qualification). A plan is also in place for early 2020 to deliver this to patients who have low-tooled access and individuals with Intellectual and Development Disability (IDD). The programme has been adapted to enable delivery within low-tooled sessions and to provide access to patients who may need more 1-1 support to undertake this practical qualification.

The Sports activity centre continued to successfully deliver the level 4 Sports Leaders programme during 2019 (with 5 qualifications achieved). In addition, the department successfully developed and introduced the level 5 Sports Leaders programme as a progression route for the learners who had completed the Level 4 qualification. The first cohort commenced the level 5 qualification at the end of 2019 and are expected to achieve this award by the end of 2020. This new level 5 is being co-delivered with patients that were appointed to the newly introduced Sports Volunteer role within the Sports department and provides patients with both practical volunteering experience and accredited learning.

Patient Volunteers - Recognising the importance of Vocational Rehabilitation as a contributing factor in recovery has driven the planning and implementation of patient volunteer roles in the Skye Centre - Sports: Patients were key in the development of the role in Sports, considering the mentor role, the benefits and challenges and identifying training needs. Following this, patients were supported through the application and interview process and 4 patients were successful. As noted above, these patients are working towards Level 5 in the accredited leadership qualification and the mentor/volunteer role provides them with the practical opportunities the course requires. The patients' feedback has been overwhelmingly positive about the impact on their own mental health of this role.

Café: 3 patients have been supported through the application and interview process and have taken up the role as volunteer in the café area in the Atrium.

There is a structured process in place to ensure that the patients in these roles have support and supervision, and there is also supervision in place for the staff identified as mentors, provided by the Specialist Occupational Therapist.

Events

The Skye Centre service continues to provide a series of planned events throughout the year. These included the Celebration of Success and Achievements Ceremony acknowledging our patients' engagement in the range of learning opportunities available to them recognising the patients' achievements and progress. The Sports' Man Dinner will hopefully be able to be rescheduled later in the year. The Patient & Carer Christmas lunches and Christmas social and spiritual events were again delivered successfully and many positive responses were received from patients and carers regarding the enjoyment and quality of service they experienced. All of these events are accessed by patients and their carers. The success of these events can be attributed to the dedication and commitment of the Skye Centre team and Person Centre Improvement Team.

Table 9 below provides detail on the number of patients attending the range of events provided over the past 12 months.

Table 9 - Patient Attendance at Events

Department	Description of Event	Date of Event	Number of Pt attendances
PLC	Patients Learning Event	Mar-2020	54
Skye/PCIT	Christmas family lunch (x2)	Dec-2019	77
Atrium	Summer evening events (x3)	Jun-Sept 2019	123

The 'Events Committee' group, established during a TSH3030 project in 2018, offered patients across the hospital an opportunity to participate in a voluntary role, as an events committee member planning the summer events. This group was facilitated by the Skye Centre's Specialist Occupational Therapist, and supported by an Education & Learning Officer from the PLC. It provided a mechanisms for patients to get involved in planning and running a range of events**.** A number of patients who were members of an Events Committee group were encouraged to participate in the 'Working with Others' core skill qualification. This qualification enabled the participants to develop and employ the necessary skills and confidence to work effectively in a co-operative group setting to plan four evening social events for patients in the Skye Centre. The group promotes employability skills and motivation for participation in meaningful occupation. Pre and post volitional questionnaire evaluation tracked changes in patient volition. Examples of feed from patients is detailed below.

Section 5 – Identified Issues and Potential Solutions

Recruitment

Every effort has been made to ensure the vacancies that have arisen over the past 12 months are being progressed. There are presently 3 vacancies (2.5 WTE) across the service at various stages of the recruitment process. (Band 4 Gardens, Band 3 Atrium, and Band 3 Shop). The recruitment for these posts was ongoing and at various stages in the process however as a result of Covid-19 this was postponed. The process has recently been recommenced and it is anticipated that the new post holders will be able to take up post within the next few months.

Sickness

The staff sickness levels across the service have decreased slightly over the past 12 months, averaging 7% in comparison to 7.91% reported the previous year. There has been minimal change in Long term sickness which is presently reported as 5.31% in comparison to 5.52% the previous year. Short term sickness has continued to decrease from 2.39% to 1.69%. The monitoring of staff sickness levels remains a focus for the Skye Centre Manager to continue to drive improvement in this area.

Section 6 - Future Areas of Work and Potential Service Development

Patient Day

Prior to March 2020 the Patient Day project had achieved an identified ward from each Hub to attend the Skye Centre for 2 sessions each week. The Skye Centre had engaged in the wider Clinical Model review and contributed to the Clinical Model Operational document which was produced. Included in this document the Patient Day model would be extended to all wards. The work related to enabling this model to be implemented was suspended as part of the enhanced model of care delivery and in the context of COVID-19restrictions. The Skye Activity Centres have remained closed since the end of March 2020 however plans to reintroduce activity are being discussed within the Gold Command structure. It has been proposed that the Skye Centre reopens in phases ensuring that the necessary infection control measures along with clinical and security risk assessments are adhered to during patients' visits to the building.

Skye Centre Induction Pathways

As part of the work to streamline and enhance the Induction programmes, the access route for patients no longer requires a referral. Instead there is discussion between Skye Centre staff and the patient's keyworker and Occupational Therapist, and discussion at the CTM. This is then recorded in the EPR (RIO) and has contributed to reducing the time taken for patients to access the Skye Centre following admission. This dialogue with key members of the Clinical Team has improved the communication and quality of information received. Plans are in place to amalgamate both the Skye Centre Induction and Sports & Fitness Induction processes in order to make this more efficient.

Provision of Activity out with 9 – 5

There has been ongoing requests from the patient group via the What Matters To You events and the PPG for more activity to be made available out with the business hours of 9 -5. The service has planned a series of evening summer events over the past 2 years which have proved to be very successful. A proposal was also approved at the Senior Management Team to commence a pilot in April 2020. This would close the hospital shop at the weekend to redeploy staff to provide a range of activities. The restrictions placed on the service due to COVID-19 has resulted in such activities being postponed at this time. However Skye Centre staff have adapted to the very different way of working. They have been creative regarding the choice of activities that can be offered within the enhance model of care and demonstrated flexibility regarding their shifts to best meet the needs of our patients. Going forward there is an opportunity to explore and adapt patterns of work to ensure that the Skye Centre service is safely and effectively delivered to meet the needs of our patients.

Patient Timetable

The patient timetable has been implemented across all Hubs and the Skye Centre and is currently informing the level of patient activity during the current enhance model of care delivery. Reporting mechanisms have been created and it is important that this system is monitored and reviewed to ensure that all disciplines are utilising it appropriately in order to provide accurate and quality data that will inform future service delivery.

Outcome Measures

A future goal for the service is to explore the possibilities to evidencing intervention across all areas of the service using a standardised measure. A recommendation is to explore the implementation of Goal Attainment Scaling (GAS) as an outcome measure. GAS is a method of scoring the extent to which a patient's individualised goal has been achieved over the course of an intervention. This allows quantitative analysis of goals across the service, whilst maintaining an individualised approach for patients. As this is a multidisciplinary rehabilitation measure it could be utilised across the service. The first aim is to pilot this in a quality improvement approach to consider its usefulness to the Skye Centre.

COVID19 Restrictions

Over the coming months it will be essential and important to reflect on the lessons learned from COVID19 and how this might inform the future shape of service delivery. This will support staff to ensure they are providing the best quality service for our patients, maximising the use of our facilities in a multidisciplinary way.

Efficiency Savings Targets

The importance of ensuring that agreed efficiency targets are achieved is also recognised. The Skye Centre service has achieved the agreed savings target last year, with £214.5k identified as recurring savings for the financial period 2019/20. For the financial period 2019/20 the agreed savings target is £150k. The necessary steps have been identified to meet the agreed savings target.

Section 7 – Financial Implications

There are no major financial implications with regards to delivering the service developments described above, however it will require new, innovative and integrated models of practice and staffing to be agreed and implemented. The desired change ensuring that the most appropriate range of activities are delivered safely and effectively.

Section 8 – Next Review Date

The next annual report will be provided to the Board in June 2021.

Appendix 1

First received	Description (Policies)	Outcome	Closed	Outcome code
14/06/2019	Patient complained that he has a garden placement on a Tuesday but recently the department has been shut. He is unable to attend Sports due to a disassociation meaning he has to sit in the Atrium for 3 hours and is fed up with the situation.	Charge Nurse apologized to patient and advised that the Skye Centre team endeavour to minimize closures. The hospital is recruiting to fill vacant positions hope that this will further reduce closures and the impact this has on patients.	19/06/2019	UPHELD
20/06/2019	Patient complained that he returned a pair of training shoes to the shop for a refund or replacement. However a week later the staff member tried to give him the same pair of shoes which the staff member had made alterations.	During meeting, patient claimed training shoes were faulty due to stitching being uneven. An inspection of the goods showed no obvious signs of damage or fault. Patient advised that as there was obvious signs that the shoes had been worn he would not receive a refund or replacement on this occasion. Patient unhappy with outcome however agreed to take the training shoes back to the ward. Patient requested staff member be reprimanded for attitude towards him when he attempted to return the goods. Patient advised that feedback the manager had received indicated the staff member had dealt with the situation professionally. However, manager agreed to provide feedback to staff member regarding how upset he was regarding this situation.	25/06/2019	NOTUP
25/06/2019	Patient complained the gym was shut on the morning of 24/06/2019, and no reason was given. Patient has a Wednesday afternoon session but cannot go to the gym at any other time as they have cut the numbers. Patient very unhappy as he enjoys going to the gym and getting off the ward, wants more placements, not being restricted to just Wednesday's.	The sports department was not closed. Patient had requested an additional drop-in session but unfortunately, it could not be accommodated. Patient has 2 planned sessions on a Tuesday and a Wednesday at sports.	25/06/2019	NOTUP
21/08/2019	Carer complained that his son is missing placements every week. He is scheduled to attend PLC on Monday, Arts & Crafts on Tuesday and Gardens on a Wednesday. Wants to know why this is happening as he feels attending these sessions is crucial to his son's well-being.	5 of the patient's placement sessions have been cancelled in last month due to staff shortages, 3 of these were in the Arts and Crafts department.	28/08/2019	UPHELD
06/11/2019	Patient complained about the attitude of a member of staff in the Skye Centre dealing with a disassociation situation.	SCN met with patient who wished to withdraw complaint.	07/11/2019	WITHDR

First received	Description (Policies)	Outcome	Closed	Outcome code
31/12/2019	Patient complained that the patient activity day is in fact a "patient inactivity day". He does not find it interesting and does not want to be subjected to this every week. Patient also raised historic issues which have been referred to his RMO.	RMO met with patient on 09/01/2020 to discuss his complaint. Patient He felt that this was the patients view rather than a complaint. Advised that the nature of the patient's complaints are part of his mental illness.	09/01/2020	NOTUP
07/02/2020	Carer complained about the way her son was spoken to by a member of staff in the patient learning centre.	Patient turned up for PLC session with snacks. Patients are discouraged from eating and drinking during sessions as tea breaks are provided. Patient disgruntled that he was asked to put snacks away and concentrate on his work. Complied putting snacks away but did not respond to encouragement to focus on his activity. Volunteer asked patient if he would like to join her in a reading activity. Patient's response was abrupt and he raised his voice. CN highlighted that the manner in which he was addressing the Volunteer was inappropriate. Patient continued to be very vocal stating that he would not be participating in any activities. Such behaviours have a negative impact on the other patients in attendance and as patient refused to calm down he was returned to the ward. Although CN was firm with patient she did not raise her voice. Patient has since returned to his session and has had a positive discussion with the Charge Nurse and apologised for his behaviour. He also indicated that he would apologise to the Volunteer when she is next in the department. It was agreed that the patient would have further discussions with PLC staff to identify learning activities that he would like to participate in and focus on during his sessions.	13/02/2020	NOTUP
07/02/2020	Carer complained his son has had 3 of his placements cancelled over the last few weeks.	Patient has 3 placements per week, PLC, Crafts and Gardens. Over the last 3 weeks the patient attended 5 out of a possible 9 sessions. The reasons recorded for the sessions were - Patient attending CPA / Patient declined / Patient had appointment on ward / Gardens closed. One session did not go ahead as the department was closed. Apologised for the closure and advised that every effort is made to minimize closures however, on occasion it was unavoidable.	13/02/2020	PART

First received	Description (Policies)	Outcome	Closed	Outcome code
25/02/2020	Carer complained his son has 2 placements cancelled one on Tuesday and one yesterday.	SCN contacted carer and explained that in both instances the sessions were not cancelled. Last Tuesday the patient was offered his placement but attended the GP instead. Yesterday the patient did not attend the PLC as his session has now been moved to Wednesday morning. There has been discussion with the patient and ward staff about this change as it is significant, moving patient from a 1-1 to a more mainstream, small group session. Parents accepting of explanation, however keen to stress how important and beneficial activity is to him, and how frustrating it is if that they were not given the correct information. The information regarding attending the GP and the change of placement is available to ward staff.	25/02/2020	NOTUP

Appendix 2
Outcome of the State Hospital What Matters to You?
Skye Centre Event June 6, 2019

How did the team facilitate the 'What Matters to You' conversations? (e.g. format, people involved, location)
The event was held in the Sports Centre and patients attended with staff and Volunteers. Tables with prepared posters were arranged by activity area to allow patients to comment on each area in turn; they were asked to highlight 'what matters most' about an area, 'how could we make it better', and then select 'three things we've agreed to do in the next 12 months'.
Positive Themes Emerging
• Highly commending staff attitude, motivation and support • Clear feedback regarding the value placed on activity, the opportunity to spend time off-ward and engage with patients from other wards. • Positive feedback regarding the value placed on Sports activities and a desire to extend access to these. • Patients spoke about enjoying the drop-in café facility and the evening social activities • Creative activities in Crafts allow patients to express themselves • Taking on responsibility for the care of the animals gives patients a sense of self-worth and purpose; also in accessing the gardens patients enjoy the fresh air, value the therapeutic benefits of the activity and report increased well-being • Positive feedback regarding the learning opportunities available • Patients are happy with the care and treatment provided in the Health Centre and as the suggestions from last year have all been implemented, there were no further suggestions for improvement in this department.
Learning Opportunities Arising
• There continue to be requests for more access to evening and weekend activities • Suggestions for volunteer roles in the café and Sports
What worked well?
A large group of patients had the opportunity to attend and take part. Patients moved around different tables at the event which meant they could give their views on each area of the service; they engaged well and appeared very positive in contributing to the event.
What could have worked better?
As some patients do not attend all areas they required support to remain for the duration of the event, once they had contributed. There was a sizeable group who chose not to remain until the end of the morning. As the plan had been that they all select 3 issues from all those identified to develop into an action plan, it was agreed that this would happen in the individual departments at a later date.

2019 'What Matters to You?' Action Plan for the Skye Centre

You should agree, in conjunction with patients, and any carers and / or volunteers who may have been involved, what actions the community can take to share best practice and how you can work together to ensure that the learning opportunities become a focus for the leadership team during the next twelve months.
The 'What Matters to You?' Action Plan should be included as part of your leadership team meeting agenda.

Priority Action(s) Agreed- Crafts		Responsible Person	Timescale	Update
1.	More themed sessions i.e. 1 day workshops	Jennifer Gardiner/Martin Govan	November 19	**Completed**, this has started and will be maintained
2.	Pop up shop for selling items	Jennifer Gardiner/Martin Govan	November 19	**Completed**, items were sold and this was successful
3.	Exhibition of work/rotate cabinet items regularly	Jennifer Gardiner/Martin Govan	November 19	**Completed**, work is displayed and new ideas for displays implemented
Priority Action(s) Agreed- Gardens		**Responsible Person**	**Timescale**	
1.	Work with senior managers to ensure gardens are open as much as possible particularly over the summer months.	Eliz Prentice	July 19	**Completed**, every attempt was made to open as much as possible
2.	Consider potential outside funding opportunities for projects such as the allotments.	E Prentice to receive email from L Tennant and put forward idea to A Maclean/J Garrity.	September 19	To date no volunteer has applied with fundraising experience; it is anticipated that when volunteers return to TSH that this vacancy will remain open and this position could assist in the application for outside funding
3.	Discuss the possibility of patients using fruit & veg in cooking sessions.	G Morrison	July 19	Not implemented this year, further plans to develop veg plots so this can happen next year

Priority Action(s) Agreed- Atrium		Responsible Person	Timescale	
1.	Implement patient café worker volunteer	Nicole Jordan/Sarah Innes	October 19	**Completed**
2.	Xbox to be available more often at patient active day	Nicole Jordan/Hazel McGinty	July 19	**Completed**
3.	Deliver a minimum of two evening social activity events	Nicole Jordan/Sarah Innes	August 19	**Completed**
Priority Action(s) Agreed- Sports		**Responsible Person**	**Timescale**	
1.	Tea/coffee available in sports area	Sandra McCourt	June 19	**Completed**
2.	Patient Volunteers/Mentors	Sandra McCourt/Allan Burnett	October 19	**Completed** Implemented successfully
3.	Consider weekend and evening activities	Sandra McCourt	December 19	TSH 30:30 project tested this out, offering evening and weekend activities.
Priority Action(s) Agreed- PLC		**Responsible Person**	**Timescale**	
1.	Water cooler for the PLC	Erica Hicks	July 19	This was explored and found to be not possible so a workaround solution was implemented.
2.	Reduce noise levels in the PLC (certain sessions)	Erica Hicks	December 19	**Completed** furniture rearranged, work spaces reconfigured
3.	Offer learning for Driving Theory Test on the computer	Erica Hicks	October 19	**Completed** This is now available for patients.

Person responsible for sharing this form and providing updates to the Involvement and Equality Lead:	Alexandra Maclean Senior Charge Nurse

Appendix 3

Active Patient Day – Patient and Staff Feedback

Emerging Themes

Positive

- Dissassociations managed effectively
- Increased resourcing – but unreliable so unable to plan
- Works well when staff have time to interact with patients and when drop-in's are available
- When PAC is available, patients can watch a film / read in a quiet environment
- Patients can socialise with peers from other wards / hubs

Negative

- Simply a transfer of day room to Atrium, very limited increase in meaningful activity
- Drop ins not readily available due to existing closed groups / tool sessions
- No quiet area
- Very busy
- Lack of clarity between ward and SC nursing staff in respect of roles and responsibilities
- Complexity of managing a large number of patients within limited space.
- Limited interest in playing board games
- Stressful and intense to manage
- Not person-centred, no choice, too difficult within existing systems to adopt an individually tailored approach

Appendix 4 Area	What has worked well for you when you have attended the Patient Day allocated session times?	Please tell us about anything you have found difficult whilst working during your ward's allocated session times	If we could make one change to improve your experience, what would it be?
Mull 1 & 2	Getting to engage with patients out-with ward environment.	Patients appointments, i.e. facilitating appointments for external visitors such as solicitors when patients are at the Skye centre or when these are made late to the ward.	**More structure** for patients not attending placement or more flexibility.
	Opportunity to observe patient interaction and behaviour with others out-with ward. This has facilitated a different therapeutic approach.	Deterioration in patient's mental health while at Skye centre.eg when patients' behaviour becomes increasingly challenging and staff have to find an area of low stimulus for quick intervention. If PAC or PLC are in use it makes is difficult trying to find an area suitable without the situation escalating.	Availability of **more activities** that patients like would likely increase participation.
		When staff have been deployed in other departments or wards, they have at times not been released early enough to return to ward which has affected routine. E.g. checking food trolley and when items are missing, meals are then delayed.	
Arran 2	Great to see patients in their placements and observe their interactions with different patients	Getting patients booked out to the Skye Centre on time due to disassociations	**Planned activities** for patients who do not attend placements
	Greater insight into what happens at the various placements	Patients who attend the Skye Centre have a lack of things to do	
Lewis 2	Interacting with the patients in the sports department during gym sessions, badminton and carpet bowls. Also getting to know other patients from other wards across the hospital	Staff having to open departments	**Better activities**, most adults don't want to sit about and play board games i.e. Connect 4 and Guess Who
	It does get the patients off the ward however activities for patients are poor at best	Skye Centre staff moaning because not up on time	**Structured activities** for patients

Appendix 4 Area	What has worked well for you when you have attended the Patient Day allocated session times?	Please tell us about anything you have found difficult whilst working during your ward's allocated session times	If we could make one change to improve your experience, what would it be?
Lewis 2	Taking part in the sports activities and interacting with the patients during these sessions. Including chatting with patients from other areas in the hospital	Forcing some patients to go off ward (older ones)	Clear guidance for ward staff whilst at Skye Centre. My impression is that ward staff attend to support patients that may not normally attend the Skye Centre
	Getting patients there and back safely is more of a relief than fulfilling	Staff being used to cover Skye Centre deficits and not supporting your ward patients	All patients who do not have grounds access could be accompanied by ward staff to attend the Skye Centre and **participate in a group film show, Sports, Garden activity rather than sit around the Atrium or ward.**
	Seeing the patients enjoying the Sports	Organisation and communication with Skye Centre staff	**More activities** for patients i.e. film shows rather than sitting around bored
	Being able to participate in other activities at the Skye Centre i.e. Sports	Patients left in Atrium, bored with no activity	Escorted walks
	At times when staffing has allowed, being able to participate in Sports, Crafts and PLC	Patients don't have a choice if they want to attend	**Different activities**, adults don't want to play board games - Monopoly, Connect 4 and Guess Who
	Getting patients off ward	Unclear of staff roles whilst at the Skye Centre	If **other areas of the Skye Centre were available** to yourself and your patients it would give you a better understanding of how these areas function, what your patients are actually doing and maybe gain new skills
	It's a good facility but not being used to full potential	Patients have been bored and forced to sit around for hours in the Atrium. Many patients seem reluctant to attend	**More structured activities**, walks, film shows, bingo or similar. Patients who attend the Atrium are bored.
	More patients get off ward and get to do things they enjoyed, whilst staff got to do the activities with the patients	No male staff in the Atrium for toileting purposes of certain individuals	**Being able to assist in other departments** such as gardens, Arts & Crafts to what our patients are doing in placements.

Appendix 4 Area	What has worked well for you when you have attended the Patient Day allocated session times?	Please tell us about anything you have found difficult whilst working during your ward's allocated session times	If we could make one change to improve your experience, what would it be?
Lewis 2		Sometimes the expectation is upon you to facilitate teas & coffees for patients and answer door etc. when you are also responsible for the patient you are attending the atrium with	
		Our patient group are having to rush in the morning in order to be at the Skye Centre in order to open the Sports for the patients, which has a negative impact on them	
		Difficult to amuse patients. Departments closed, despite this Lewis staff were asked to take Skye Centre responder packs and both AM & PM sessions. As well as being asked to escort non Lewis patients around the grounds to return them to their wards. My understanding of the Active Day was that we were there to support Lewis patients.	
		Organising escorted patients in time is difficult. Ward can be chaotic and stressful for staff to manage safely.	
		Patients without placements sit about doing nothing	
		Do patients have the choice or option not to go?	
		Is the active day for Lewis 2 or Lewis 1,2 +3)	
		It's not easy to sit and play cards with one patient if you are sitting in the Atrium	
		No male staff in the Skye Atrium to assist patients with toilet	

Appendix 4 Area	What has worked well for you when you have attended the Patient Day allocated session times?	Please tell us about anything you have found difficult whilst working during your ward's allocated session times	If we could make one change to improve your experience, what would it be?
Lewis 2		The expectation to make teas & coffees most of the time or being a the front door most of the session when we are meant to be there to assist our patients	
Iona 3	Good for patients who enjoy sports, and some patients who enjoy movies	There are times that the patients are unable to access the PAC room.	Provide activities which are **more patient centred and tailored to specific needs.** Own staff looking after own patients
	Change of environment for patients providing an opportunity to assess out with the ward setting	Patients stuck in a room watching TV, swapping one day room for another	Ward staff should be used to engage with their own patients
	Allows ward staff opportunity to get involved and work alongside Skye Centre staff and assist and get involved in participating in activities with patients	Ward staff are used fill Skye Centre deficit's to open other departments and are not following their patients	Better structure to suit ward routine.
	Skye Centre staff have been helpful with a challenging patient on the ward, allowing him to help in the shop and giving him his own space depending on presentation	A few times it has been a bit rushed in the ward, preparing all patients and staff to relocate to the Skye Centre. Can be a bit tights for time on return to ward to do RIO notes, lunches etc.	Explore other options rather being asked to sit in PAC, feels like swapping one dayroom in the ward to another dayroom at the Skye Centre
		Not patient centred	
		Trained staff are not informed that they are in charge and then are emailed with a request to validate entries on RIO. In particular for patients they are not familiar with.	
		Staff feel there is little therapeutic benefit to patients Skye Centre not providing anything that can't be done on ward/Hub	

Appendix 4 Area	What has worked well for you when you have attended the Patient Day allocated session times?	Please tell us about anything you have found difficult whilst working during your ward's allocated session times	If we could make one change to improve your experience, what would it be?
Skye Centre	Staff communication between the wards and Skye centre staff has improved.	Patients haven't always arrived on time sometimes it's been after 10:00 and after 13:45.	Have patients up on time so they benefit fully from the activities that the Skye Centre has to offer.
	Staff participation from ward staff has improved in delivering patient activities.	When really busy the PAC wasn't always available for the Active Day Project.	Designated co-ordinator should be in the main atrium area at the busy periods to ensure efficient management.
	Sports have introduced Tea and coffee flasks into the area this has meant we can run the department independently. There is no delay getting patients to the Atrium for a break, this has meant less congestion in the Atrium and it's easier to manage disassociations.	Ward staff being allocated as a 4th person when you have the responder because ward staff are sometimes late this means you can't respond.	**Select an appropriate mix of patients to attend** – this may be difficult with the current clinical model and may need to be revisited when the new clinical model is introduced.
	Majority of staff from wards have linked well with Skye Centre staff to ensure safe and secure environment / patient care and ongoing activities.	At the beginning and end of sessions (hot spots) there can be a high number of patients to staff ratio due to ground access patients attending before staff that arrive with the escorted patients and leaving after same.	Is it possible for hub to share their active day slots? – e.g. 1 ward in Lewis comes a half day per week and a different Lewis ward comes another half day per week.
	The PAC room being available helps ease congestion in the Atrium.	On occasion there can be too many people co-ordinating the activities within the Atrium.	

Appendix 4 Area	What has worked well for you when you have attended the Patient Day allocated session times?	Please tell us about anything you have found difficult whilst working during your ward's allocated session times	If we could make one change to improve your experience, what would it be?
Skye Centre	Patients are encouraged to spend time in an off-ward environment, promoting opportunities to engage in meaningful activity. Staff from ward areas are integrated into working in Skye centre departments which is positive for patient recovery as staff are connected to patients' off-ward experiences – supports recovery principles. Staffs are able to help open departments.	Escort to Skye Centre can be delayed due to various ward based factors which impact on the patients being late for planned placements, staff not being available to go to departments and escorting staff being stuck in the ward waiting to attend the Skye centre.	
		Patients attending active day are a mixed group of patients in terms of their risk / needs / stage in their journey which causes difficulties. The patient active day does not meet individual patient need - this does not meet the needs of many of the patients who attend – for example, patients with complex needs such as dementia. Not necessarily person-centred care.	
		Staffing levels do not allow patients from the active day to all be offered activity which meets their needs – one size does not fit all. Departments open are not able to tailor to all patient active day patients' needs due to many of the patients severe volitional issues.	

Appendix 5 **Patient Day Project - Action Plan**

Action	Update	Lead Individual(s)	Timescale for Completion
1. To review individual patient timetables and in conjunction with the Clinical Team to identify appropriate activity and promote attendance at planned activity sessions.	Work ongoing re RIO patient timetable. System to be rolled out to remaining 3 hubs. Senior Occ Therapist providing Skye Centre Induction reports to CTM's. Ongoing discussions re individual patient care plans.	Skye Centre Senior Nursing/Senior Occupational Therapist/Clinical Team Members	March 2020
2. To develop an Induction pack for ward nursing staff attending the Skye Centre to provide clarity regarding roles and responsibilities	Induction pack has been devised with input provided from Skye Centre Atrium staff	Skye Centre SCN	November 2019 **Completed**
3. To implement the Induction pack for all nursing staff attending the Patient Day sessions for each ward	Induction pack has being made available to all visiting ward staff and will be available for all new staff going forward who are attending ward sessions	Skye Centre Charge Nurses/Senior Rehab Instructors	December 2019 **Completed**
4. To extend Patient Day sessions over the weekend for Mull 2	Mull 2 Patient Day session will be extended to provide a weekend session as part of the Skye Centre Weekend Activity Pilot.	Skye Centre SCN/Mull SCN	January 2019 April 2020
5. To provide Patient Day Session for Iona 2	This has not been progressed due to gap in SCN within this area and the impending review of the Clinical Model. Will be considered as part of the Logistics Sub Group	Skye Centre SCN/Iona SCN	January 2020 May 2020
6. To agree and provide monthly KPI data for SCN/Lead Nurses and Senior Skye Centre staff.	Report format agreed and KPI data provided to SCN's for each ward	Skye Centre Manager	January 2020 **Completed**
7. Communicate with members of CTM regarding process for booking available spaces to meet with Patients whilst at the Skye Centre	Members of each Clinical Team were reminded that space/rooms can be made available within the Skye Centre to meet with patients.	Skye Centre Senior Charge Nurse	November 2019 **Completed**

Action	Update	Lead Individual(s)	Timescale for Completion
8. To review escorting arrangements for each ward attending to ensure safe and effective access and egress whilst attending Patient Day session	Ongoing discussions took place with the Security Team regarding safe working practices, and to ensure compliance with existing policies/procedures. Further dialogue will take place as part of the Security Clinical Model work stream regarding any future changes to practice that may be required as part of the implementation of the revised Clinical Model.	Skye Centre SCN/Ward SCN	**Ongoing**

Paper No. 20/30

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2020
Agenda Reference:	Item No: 10
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
	Clinical Effectiveness Team Leader
Title of Report:	Quality Assurance and Quality Improvement in The State Hospital
Purpose of Report:	For Noting

1 SITUATION

This report provides an update to The State Hospital Board on the progress made towards quality assurance (QA) and improvement (QI) activities in April and May 2020.. 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. It was agreed in January 2020 that the Board would receive a report at every meeting on the range of QA/QI activities from April 2020.

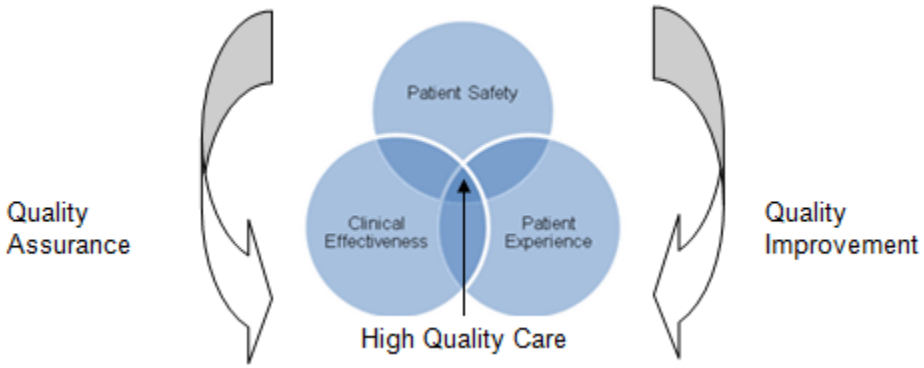
2 BACKGROUND

Quality Assurance and Improvement in The State Hospital links to the Clinical Quality Strategy 2017 – 2020. The State Hospital Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care within The State Hospital. 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

Quality Assurance and Improvement activities are embedded throughout the work of The State Hospital. The Clinical Governance Committee receive reports from groups and services to provide assurance of quality and examples of improvement. These, and other examples of quality improvement activity will be reported to the Board through the course of the year. This paper outlines key areas of activity in relation to:

- Quality Assurance through:
  - Clinical audits, variance analysis tools and complaints
  - Service reports for Research Committee and Clinical Effectiveness
  - Clinical and Support Services Operating Procedure Indicators Report in response to COVID-19
- Quality Improvement through:
  - The work of the QI Forum through supporting staff engagement
  - Realistic Medicine
  - The State Hospital response to the coronavirus pandemic
  - Evaluation of TSH3030
- Evidence for quality including analysis of the national and local guidance and standards recently released and pertinent to The State Hospital
- An overview of the capacity building activity to support QA and QI

4 RECOMMENDATION

The Board are asked to note the content of this paper

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Quality Improvement and Assurance report supports the corporate objectives by outlining the actions taken across the hospital to support QI and QA
Workforce Implications	None
Financial Implications	None
Route To Committee / Group	This paper would normally be reviewed by CMT then presented to the Board, however due to the suspension of CMT with the current Incident Command Structure, this paper will be presented straight to 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 √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

Paper No. 20/30

QUALITY ASSURANCE AND IMPROVEMENT IN THE STATE HOSPITAL

JUNE 2020

INTRODUCTION

Quality Assurance and Improvement in The State Hospital links to the Clinical Quality Strategy 2017 – 2020. The State Hospital Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care within The State Hospital. 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.

This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities in April and May 2020.. 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. A range of services and committees report on their quality assurance and improvement activities throughout the year. This report will present these over the course of the year to provide a cohesive overview of the QA/QI contribution to The State Hospital realising its Quality ambitions.

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.

There was a pause with the clinical audit plan between 1st April and 15th May due to COVID- 19 being the priority within the hospital. Recent audits completed between 15th May and 31st May include:

- High Dose Prescribing Audit. This audit provided excellent assurance to the hospital that patients on high dose medication were being monitored as per the policy.
- Pre-Admission Assessment Audit. This audit included a few areas for improvement including:
    - Completion of the Pre-Admission Specific Needs Assessment included within future Doctor's in Training induction to raise awareness.
    - Ensuring medical staff are aware of the importance of completing the Pre-Admission Specific Needs Assessment form to allow other professions within the hospital to be prepared with any special equipment or services on the patient's admission.
    - A system to be put in place to monitor the use of the form and the implications on the patient for the form not being completed
    - Each individual receiving the automatically generated email from RiO and reviewing the content of the Pre-Admission Specific Needs Assessment should ensure a progress note is entered into RiO evidencing their review of and any resulting actions from the completed form.

The audit plan has now recommenced with the following audits underway at present:

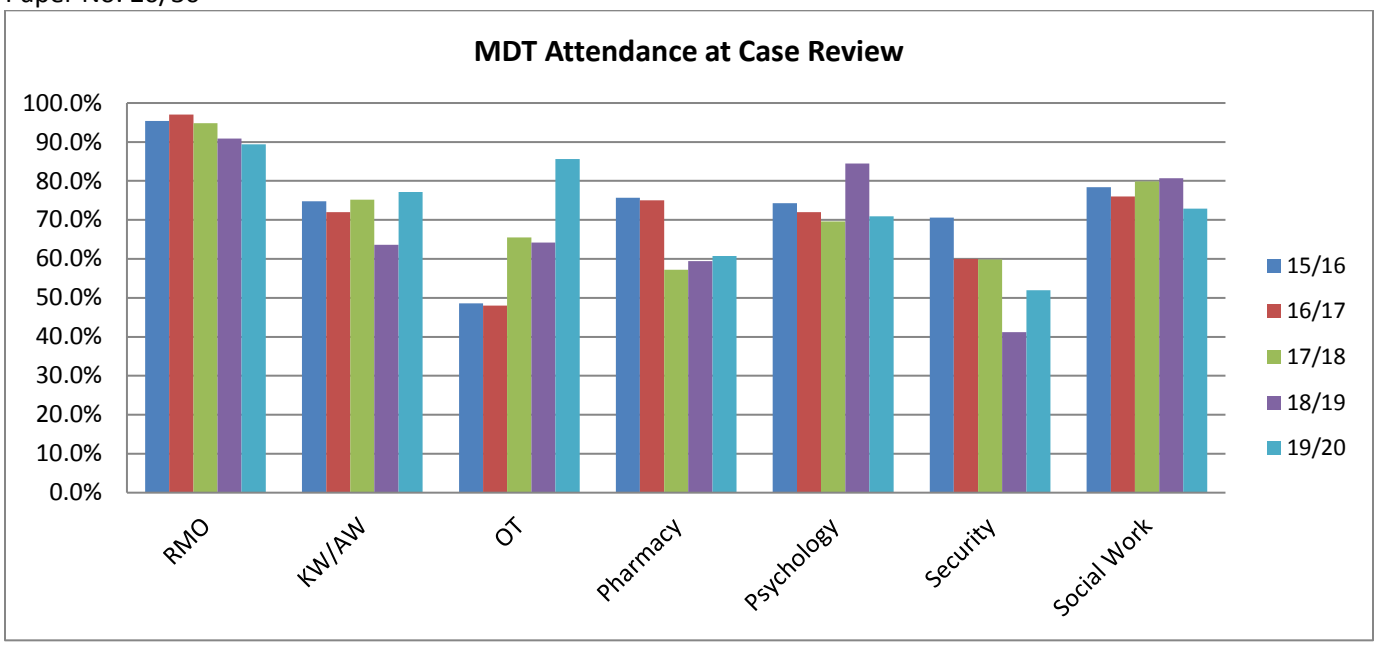
- Clozapine Monitoring Audit
- Observation Policy Audit
- Prescription Sheet Audit
- Record Keeping Audit
- Post Physical Intervention Audit

It is expected that by the Board Meeting in August Clinical Effectiveness should have met their plan of work.

Variance Analysis Tools

Variance analysis tools are used within the organisation to give assurance that the key interventions linked to the CPA reviews are being completed. During the current reporting period the annual report was drawn up giving assurance that many of the measures are meeting their targets. An improvement plan has been drawn up and will be taken to Clinical Governance Group in June for agreement for interventions that need further improvement. Areas of improvement included:

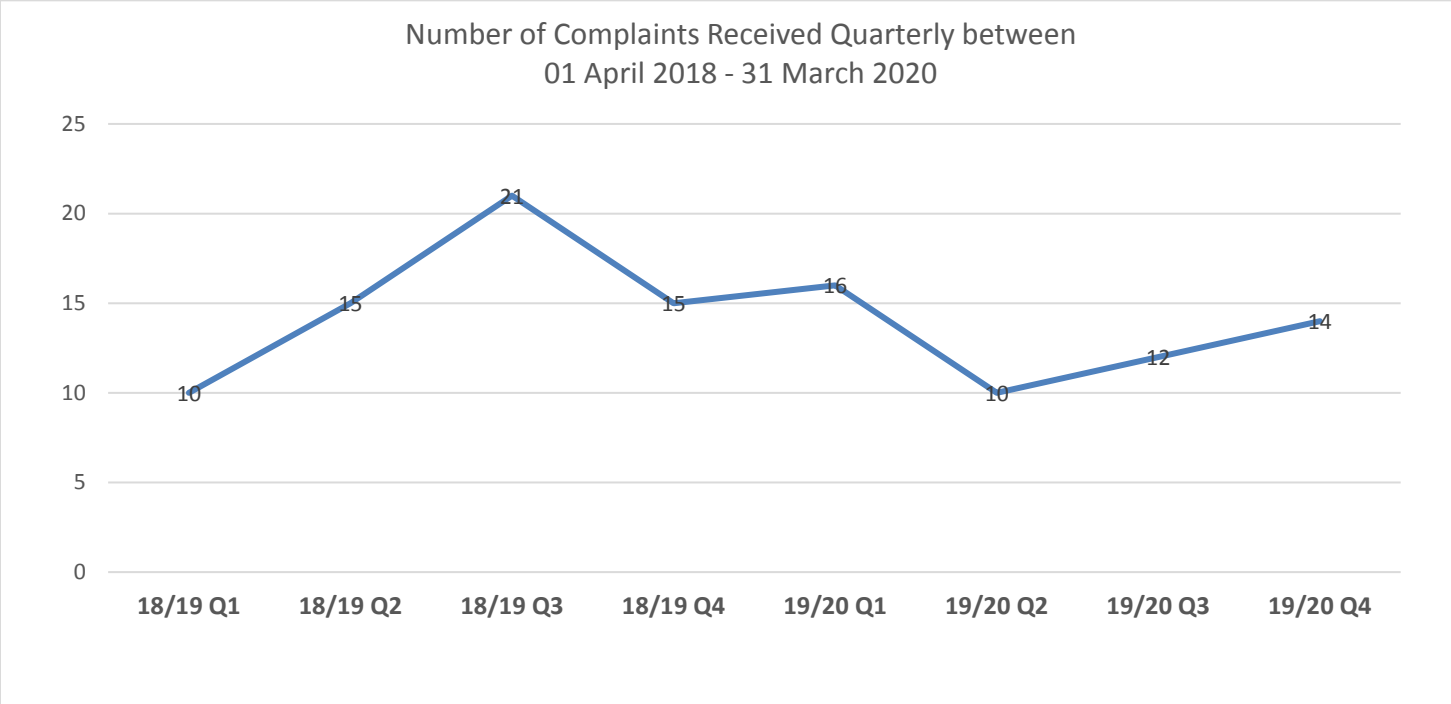
- Improvement in all hubs of patient attendance at Case Review
- Excellent improvement in all Occupational Therapy interventions
- Excellent improvement in all Dietetics interventions
- Overall provision of the professional reports was very good
- Overall improvement in how often the professional discussed their report with the patient prior to their Case Review.
- Third consecutive year of increase for carer attendance at the patient's Case Review.

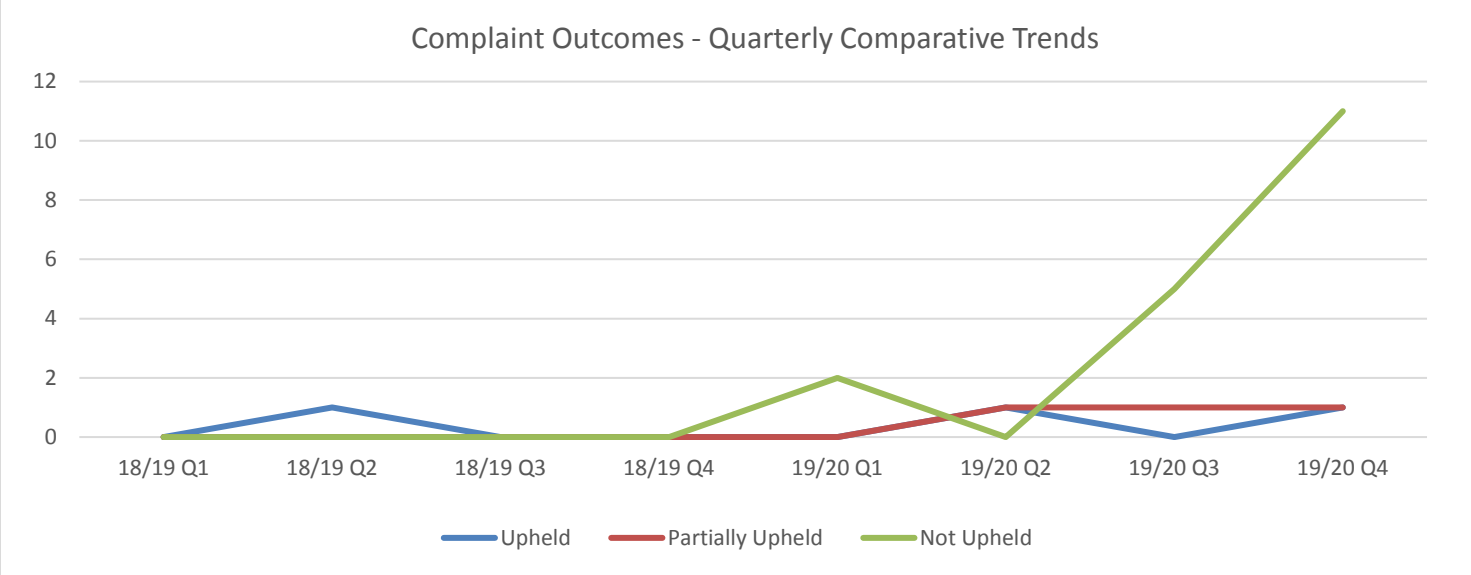


Learning from complaints and feedback

The Model Complaints Handling Procedure (MCHP), was implemented in April 2017, this was revised from the previous complaint handling process by the Scottish Public Services Ombudsman (SPSO) with an emphasis on early resolution. It is intended to support NHS Boards to take a consistently person centred approach to managing complaints. It aims to implement a standard process which ensures that NHS staff and people using NHS services can have confidence in complaints handling. It also encourages NHS organisations to learn from complaints in order to continuously improve services

The graphs below outlines the number of complaints received per quarter and the breakdown of whether these were upheld, partially upheld or not upheld.

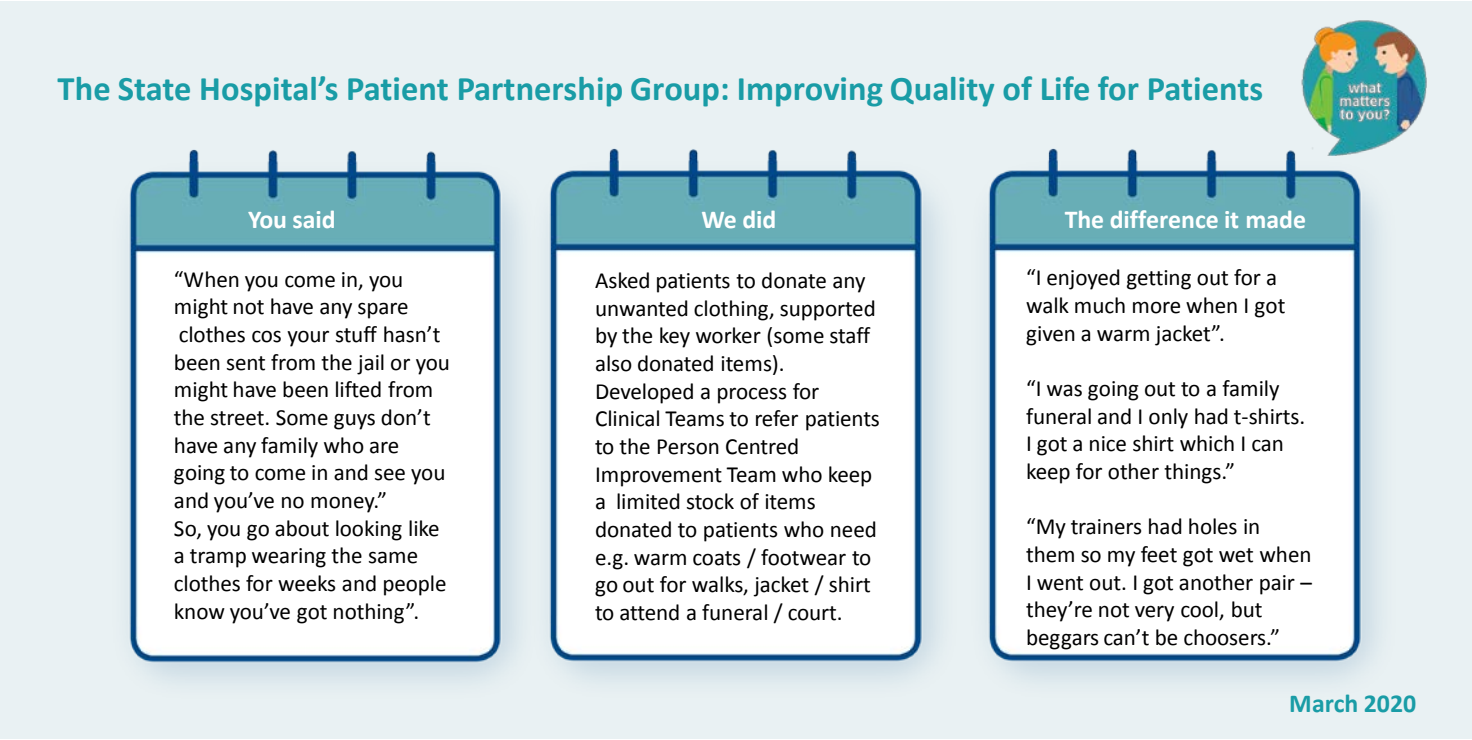




Feedback

Feedback for Q4 included:

- 36 pieces of feedback shared.
- 10 related to the patients' meal service.
- 9 highlighted learning opportunities attributed to the 'Quality of Life' indicator.
- 6 pieces of feedback were shared by carers.
- Patient Partnership Group contributed to 4 Policy Consultations.
- 'What Matters to You?' case study demonstrating direct link between feedback shared and service delivery improvements specifically relating to quality of life for patients.



Quality Assurance activities from Service Reports

The 12 monthly Research Committee report was tabled at the Clinical Governance Committee. The main areas of focus were the range of research activity, its dissemination undertaken by The State Hospital staff over the period of 2019/20, and the implementation of research findings into practice. The report also provided details of the annual Research and Clinical Effectiveness conference, and the Forensic Network Research conference. The report also specifically addressed additional ways to monitor performance and highlighted the actions taken to address previously identified priority areas for research.

Clinical Effectiveness prepared their annual report that will be tabled at the Clinical Governance Group in June. The report highlights included:

- 23 Clinical audits were completed. All clinical audit reports contain recommendations to ensure continuous quality improvement and action plans are discussed at the commissioning group;
- there have been 184 pieces of standards, guidance and reports issued during the reporting year that have undergone relevancy checks by the Standards and Guidelines Co-ordinator. From these, 42 were found to be relevant to the hospital's patient population, 13 of which required completion of an evaluation matrix;
- on a quarterly basis Variance Analysis Tool trend data is sent to Hub Leadership Teams with professional attendance at case reviews being monitored in line with key performance measures. This year annual reports were presented to the Clinical Governance Group and action plans produced for highlighting areas where improvement is required. Going forward the action plans will be set by the Clinical Governance Group and monitored by the Mental Health Practice Steering Group;
- 34 policies were uploaded for staff consultation and 40 policies had full reviews undertaken
- Clinical Effectiveness supported over 20 additional projects, working with approximately 45 staff to support them to implement QI approaches and understand more fully the data that they collect.

Clinical and Support Services Operating Procedure in response to COVID-19

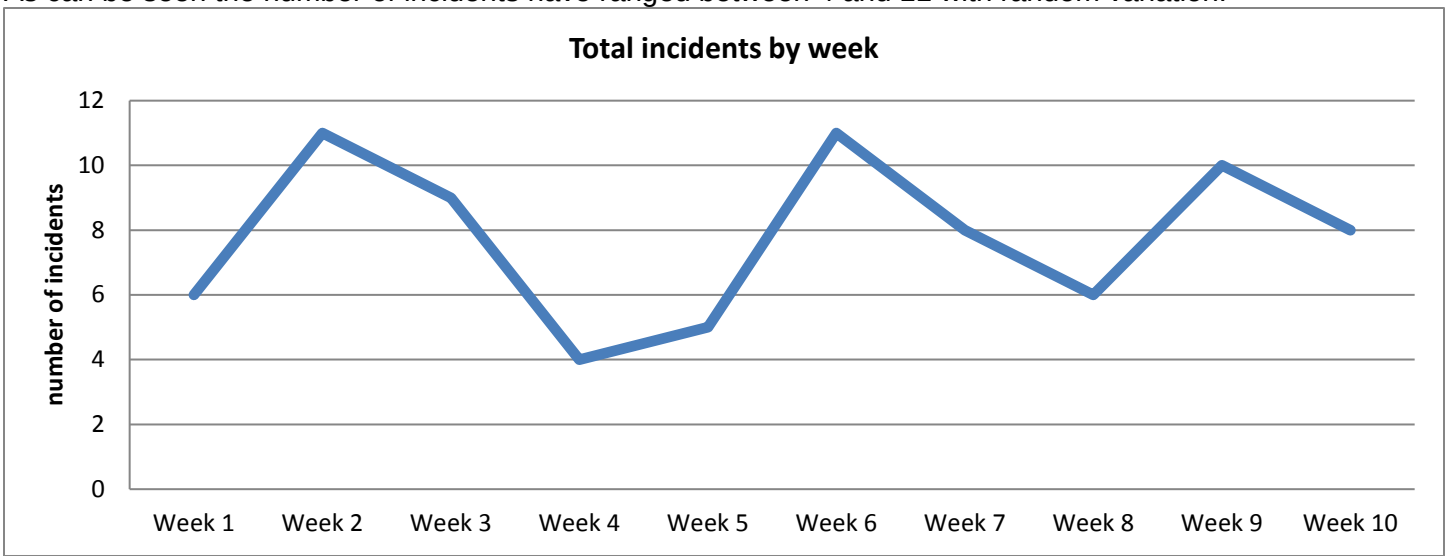
During the current Novel coronavirus (COVID-19) outbreak, The State Hospital's Gold Command Committee agreed it was necessary to introduce a further range of enhanced measures to best ensure the health and wellbeing of our patients. This Interim Clinical and Support Services Operating Procedure was developed and describes the adjustment made to care from 30th March 2020.

An indicators report is provided to the Director of Nursing & AHPs and the Medical Director on a daily basis to give the hospital assurance around the patients physical and mental wellbeing. A weekly report is then collated and discussed at the Clinical Operations Monitoring Group which is attended by a wide range of multidisciplinary team colleagues. The weekly meeting enables collaboration on interpretation of data and agreement on actions to be taken as a result analysis. It also allows for refection and assessment on the safe continuation of the Interim Clinical Operations Policy and this is reported to Gold Command on a weekly basis. The indicators included within the report are:

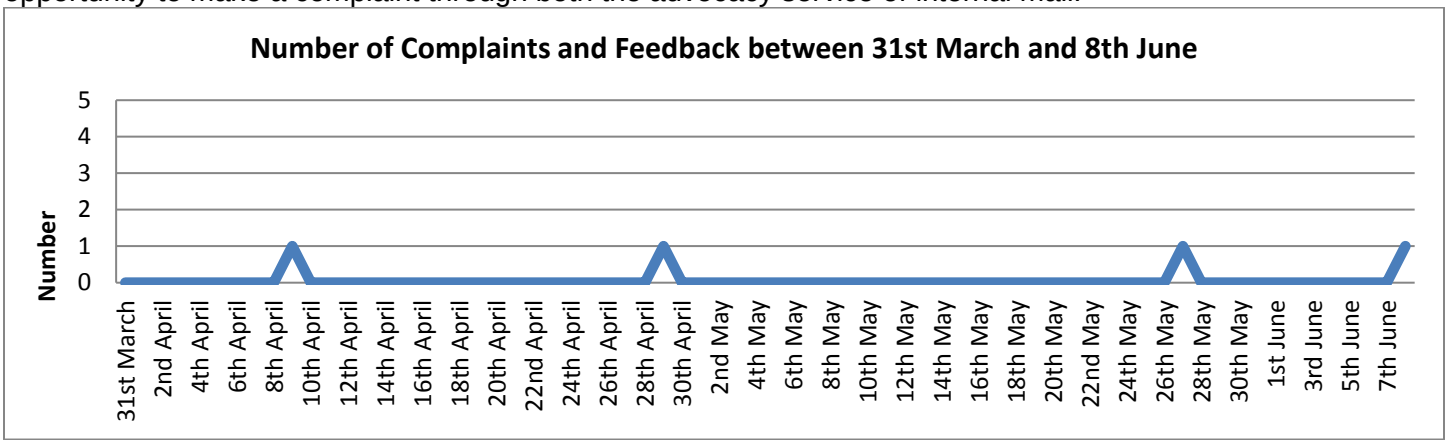
- Datix incidents around assaults, attempted assaults and behaviour (includes verbal)
- Complaints
- Feedback
- Ward staff shortages (with details of the professions backfilling)
- Number of patients on Level 3 observations (including incidents they have involved them)
- Number of patients with an increased DASA score (is an indicator of patient's mental wellbeing)
- Episodes of Seclusions
- Number of patients unable to tolerate isolation
- Episodes of SRK (soft restraint kit)
- Number of patients not accessing fresh air
- Number of patients not accessing physical activity
- Number patients not accessing fresh air or physical activity

The weekly data has allowed the hospital to have assurance that the revised policy is not too restrictive to our patients within the hospital. Examples of the weekly data are:

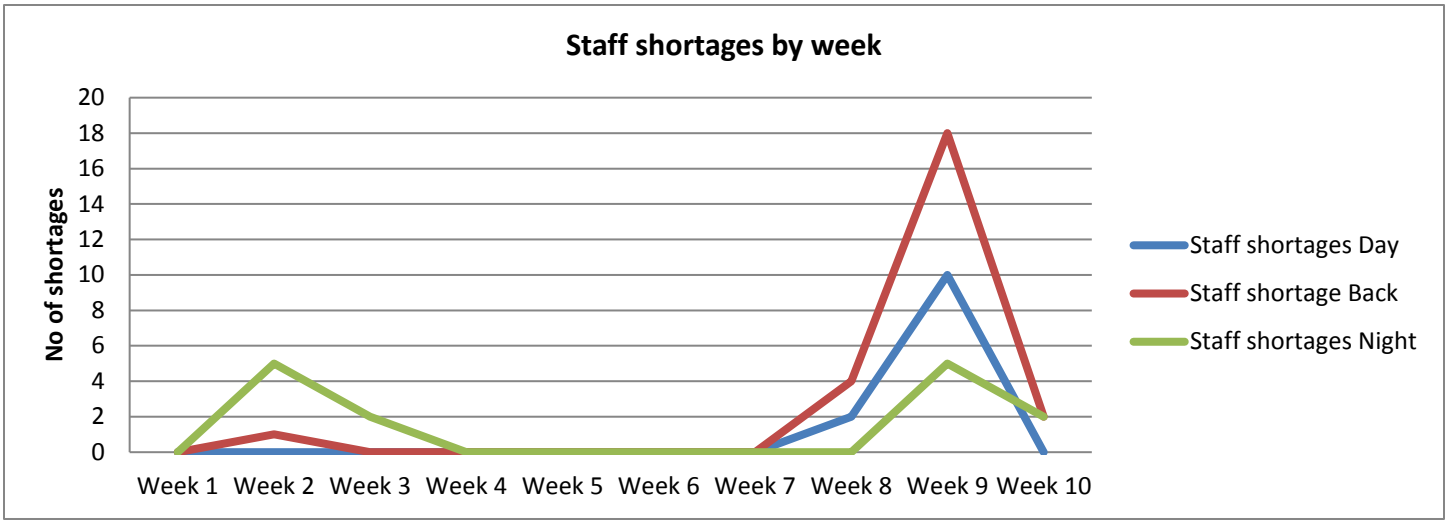
As can be seen the number of incidents have ranged between 4 and 11 with random variation.



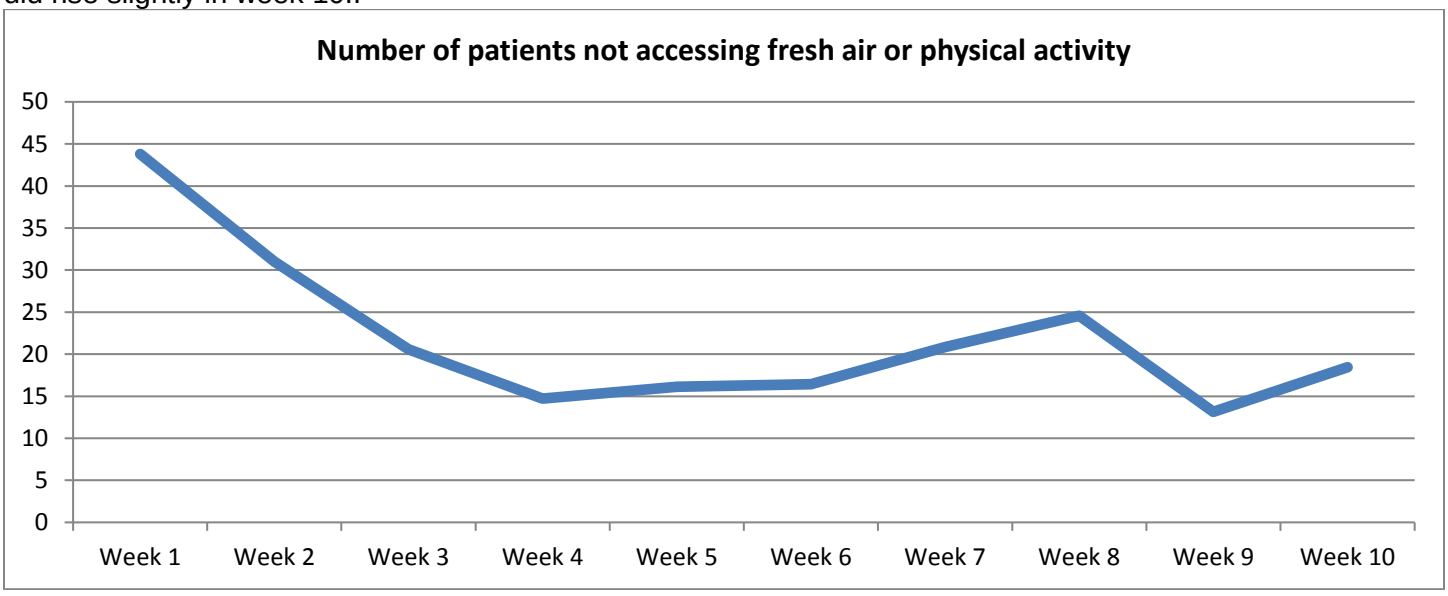
Complaints have been quite low with only 4 received to date. The patients are still being given the opportunity to make a complaint through both the advocacy service of internal mail.



As can be seen an astronomical point was seen in week 9 but has come back down within normal limits in week 10.



The average number of patients not accessing fresh air has improved significantly from week 1 although did rise slightly in week 10..



QUALITY IMPROVEMENT

The State Hospital places a priority in designing and delivering quality improvement programmes, including the patient safety programme. The need to focus on continually improving quality of care for patients is ongoing and has challenges with both operational and financial pressures. *Improving* quality and reducing costs to deliver better outcomes at lower cost (improving value), can be achieved for example by reducing unwarranted variations in care and addressing overuse, misuse and underuse of treatment. There are many examples across the NHS showing that even relatively small-scale quality improvement initiatives can lead to significant benefits for patients and staff, while also delivering better value

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.

Quality Forum and Staff Engagement

The Quality Forum meets regularly to champion and lead the quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. To support recovery and renewal planning and engage staff to ensure learning from the current situation informs future plans, a series of staff engagement activities have taken place across The State Hospital. The Quality Forum has supported staff engagement activities with a view to building in quality improvement approaches and methods to recovery and renewal planning across the site. A staff survey was developed to gather feedback on the following:

- *What is going well and why?*
- *What new practice would you want to embed in future working?*
- *What would we need to change or amend as we continue in the current situation?*

Over a six week period, 39 responses to the staff survey were received, 9 teams and 30 from individuals. From these a series of themes emerged which include:

- Communication
- Activity for patients
- Technology enabled flexible working practices
- Organisational culture, values and behaviours
- Staff wellbeing

Building on these themes a series of 13 conference linked discussions have taken place between the 27th May and the 8th June, involving over 150 staff form a wide cross section of teams across the organisation. Emerging

themes will be considered form a strategic planning, quality improvement process and innovation perspective to identify the strategic and process responses to support quality of care, staff wellbeing, innovation in practice and system redesign. Feedback from patients and carers, stakeholders and volunteers will also be used in inform these developments.

Quality Improvement in The State Hospitals Response to Coronavirus

As noted above The State Hospital has responded to the unprecedented global Covid-19 pandemic through the prioritisation of strategies to protect the health and wellbeing of patients and staff and to minimise, as far as possible, the risk of transmission of the virus through staff and patient populations. This has necessitated unprecedented changes and innovation in how services and care are delivered. Staff have created a wide variety of new processes which have been implemented at pace and subsequent adjustments made from learning, notably there has been;

- Introduction of video visiting
- Introduction of Near Me consultation
- Weekly monitoring and adjustments made to practice form the Interim Clinical Operational Policy
- Introduction of flexible and remote working practices
- Establishment of a staff wellbeing zone

TSH3030 Evaluation

The State Hospital has implemented a quality improvement initiative TSH3030 for 2 years, in 2018 and again in 2019. The most recent cycle of TSH3030 launched in September 2019 and invited teams to form and work on a Quality Improvement project. This cycle of TSH3030 brought applications in from 38 teams, 28 teams went onto complete the 4 week challenge and submit final poster and cumulated in an awards ceremony on 19th December. The initiative was again seen as a great success.

Evaluation of the improvement initiative was recently carried out, with 29% of teams involved completing the evaluation to provide feedback on the process and impact. The majority of the feedback on the 2019 TSH3030 initiative was positive with teams highlighting the benefits of multidisciplinary work and the support provided to projects from across the hospital. The visibility and status of projects being conducted as part of the event seems to have generated support and allowed teams to commence pieces of work that may otherwise have been more difficult or time consuming to initiate. The main factors that teams identified as being related to successful completion either as a part of their 2019 project or as learning for any future QI work were

- Multidisciplinary teams
- Identified roles for each team member and engagement from all team members
- A willingness to embrace change to support improvement
- A higher level of preparation and planning prior to the commencement of the project
- The need for a focused attainable aim
- QI training and the resources provided through the QI zone were highly valued in supporting 30:30 project and the use of QI methodology.

The feedback also highlighted some difficulties in conducting projects as part of TSH30:30 and these should be considered by the QI Forum in relation to planning for any future 3030 event or wider QI initiative. The main issue noted was the time required to provide the weekly poster required by TSH30:30, and the time of year at which the initiative is scheduled. The QI mentor involvement was valuable and suggestion that this could be more structured, although this may require a reduction in the number of projects that are able to be supported. The feedback on the QI training programme and QI Zone resources was very positive and using these things to increase TSH QI capacity should be an ongoing focus.

Quality Improvement activities from Service Reports

Two twelve monthly reports were deferred at the Clinical Governance Committee in May 2020. These were the Medicines Committee and Infection Control Committee. Both these services were heavily involved with the hospital response to the Covid 19 outbreak.

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 Standards and Guidelines Co-ordinator. During the period 1 April to 31 May 2020, 39 guidance documents have been reviewed, none of which require the completion of an evaluation matrix.

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Healthcare Improvement Scotland (HIS)	6	4	0
Mental Welfare Commission (MWC)	10	9	0
SIGN	3	1	0
Scottish Government	2	1	0
National Institute for Health & Care Excellence (NICE)	17	5	0
Healthcare Quality & Improvement Partnership	1	1	0

As at the date of this report, there are currently 4 evaluation matrices awaiting review by their allocated Steering Group. The progress of all 4 evaluations was temporarily paused due to The State Hospital adapting to the COVID-19 pandemic however as per Gold Command, action on gap analyses completion will begin again at the start of July 2020.

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 waiting on Project Lead to take to Patient Safety Group for review.	15/01/2019
MWC	The use of seclusion	MHPSG (via Patient Safety)	Evaluation matrix in draft, waiting Director of Nursing to take to Patient Safety Group for review.	10/10/2019
MWC	Autism and complex care needs	MHPSG	Evaluation matrix in draft, awaiting allocation of outstanding recommendations before sign off by MHPSG.	30/10/2019
SIGN	Assessment, diagnosis and interventions for autism spectrum disorders	MHPSG	Initial evaluation matrix to be updated in line with content of MWC Autism guidance released 30/10/2019. Evaluation matrix in draft, awaiting allocation of outstanding recommendations before sign off by MHPSG.	June 2016

For each of the 4 Steering Groups available to review guidelines, a Guidelines Action Plan is created to record the progress of any outstanding recommendations to be achieved.

	Total Outstanding Recommendations	Total Outstanding Guidelines
Physical Health Steering Group	3	3
Mental Health Practice Steering Group	13	6
Person Centred Improvement Steering Group	1	1
Medicines Committee	4	2

CAPACITY BUILDING FOR IMPROVEMENT AND ASSURANCE

The State Hospital has a range of Quality Improvement leaders supporting QI initiatives. There are four senior staff who have completed the ScIL Programme - Scottish Improvement leads and a Consultant Psychiatrist who has competed the Scottish Quality and Safety Fellowship. The QI leads have established a Quality Forum

which meets regularly throughout the year and promotes QI approaches and methods. They host QI cafes to support ongoing projects, QI Connect to connect to international webinars on topical QI issues and delivered 2 days of training for The State Hospital staff in October, this focused on the model for improvement, settings aims statement, measurement for improvement and spreading improvement.

Given the recent circumstances of the Coronavirus pandemic, it is unclear what national opportunities there will be for QI training. The Quality Forum will work with national partners to scope out opportunities for staff development. National QI forum of Executive Leads has continued to meet to offer peer support regarding learning from the experience of service response to COVID -19 and planning for recovery and renewal. National collaboration will continue to feed into The State Hospital planning process for capturing organisational learning and feeding this into future planning.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the Clinical Governance Committee Meeting held on Thursday 13 February 2020 at 9.45am in the Boardroom, The State Hospital, Carstairs **CGC(M)20/01**

CHAIR:

Non Executive Director	David McConnell

PRESENT:

Non Executive Director	Nicholas Johnston (via teleconference)

IN ATTENDANCE:

Chairperson	Terry Currie (via teleconference)
Chief Executive	Gary Jenkins
Head of Psychology Services	John Marshall
PA to Medical & Associate Medical Directors	Jacqueline McDade
Head of Corporate Planning and Business Support	Monica Merson
Director of Nursing and AHP	Mark Richards
Consultant Forensic Psychiatrist	Gordon Skilling (part)
Clinical Effectiveness Team Leader	Sheila Smith
Medical Director	Lindsay Thomson
Security Director	David Walker (part)

1 APOLOGIES AND INTRODUCTORY REMARKS

David McConnell welcomed those present to the meeting and apologies for absence were noted from Robin McNaught and Maire Whitehead.

Following a brief discussion, it was agreed that Agenda Item 15 be deferred to the next meeting.

Action: Jacqueline McDade

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business to be discussed.

3 TO APPROVE THE MINUTES / ACTON NOTE OF PREVIOUS MEETING HELD ON 14 NOVEMBER 2019

The Minutes of the previous meeting held on 14 November 2019 were amended on page 6, Agenda Item 12 to show that the report was presented by Monica Merson, Head of Corporate Planning and Business Support, and were subsequently approved as an accurate record.

4 PROGRESS ON ACTION NOTES

All actions are progressing or have been completed.

5 MATTERS ARISING

There were no further matters arising.

Dr Gordon Skilling joined the meeting at this point

6 MENTAL HEALTH PRACTICE STEERING GROUP 12 MONTHLY REPORT

Members **received** and **noted** the Mental Health Practice Steering Group 12 Monthly Report, which was presented by Dr Gordon Skilling, Consultant Forensic Psychiatrist.

The Main role of the group is to continue to maintain and improve standards of mental health care for patients. The group is represented by members from multidisciplinary teams within the Hospital. The group continues to function well.. Meetings are scheduled every month and during the report period 9 meetings were held and 3 meetings were cancelled due to quorum issues. There are ongoing issues with nursing attendance at the group and it is proving problematic having a consistent person attending.

One main area of work is being aware of, reviewing and ensuring we implement evidence based guidelines and standards from various external professional agencies, NICE, ICE, MWC, etc. The Clinical Effectiveness Department have a good system in place for picking up when new guidelines are published, including those by the Ombudsman.

Within the reporting period, 22 pieces of guidance or standards were published half of which are relevant to the State Hospital; examples of these are neuro for PTSD, substance misuse which is led by Dr Callum MacCall and general anxiety which is led by Dr Natasha Billcliff.

Risk assessments are completed and monthly data presented to the group. There are no issues around completion or quality of risk assessment processes.

Discussions have taken place around the overlap of the Relational Approaches To Care and Trauma Informed Groups and it has been agreed that they will continue as is, although there is some shared working they can do. Work is ongoing on a joint training package for staff and online modules.

A key piece of work for the group is to focus on the clinical outcomes monitoring report; there is an ongoing challenge to engage clinical teams in seeing the value of this work and them using it to improve practice or identify areas in which to improve practice. There is work to be done in getting nurses on the ward to look at data for improvement purposes. A suggestion is to have conversations with frontline staff to find out what they would find helpful to know and how we display that information to get regular feedback on their daily work. The Quality Improvement agenda ties in with this by getting staff to measure and improve practice more frequently.

A positive piece of work to note is that, in conjunction with the Skye Centre team, work was undertaken to shorten the length of time before patients get involved in the Skye Centre

Work is ongoing around shared decision making and how we hear the voice of patients more, particularly in relation to CPAs and Advance Statements. Work is ongoing with the Iona 2 team to develop a tailored approach to supporting the more meaningful involvement of patients with an Intellectual Disability, who have shared feedback around difficulties in understanding and contributing to the CPA process.

A small scale test of change is underway as part of the TSH3030 initiative to trial a process to more effectively tailor the CPA meetings to the values of each individual patient and as a result improve engagement, satisfaction and the ability of teams to co-produce care plans.

Work in the area of Realistic Medicine has primarily been focussed on building QI capacity and awareness within the hospital and supporting improvement initiatives such as TSH3030, the QI Cafes and the recently launched QI Essentials training programme. There is ongoing discussion around how to better engage frontline staff in the use of data for improvement and the MHPSG has supported various projects aimed at building a more personalised approach to care.

Terry Currie highlighted the obesity problem reported on page 8 and asked why we are unable to

resolve the issue of grounds access more quickly. Gordon Skilling advised that hubs have varying ways of dealing with grounds access. Feedback received highlights that the grounds access process is an inefficient paper based system at present which leads to delays between the ground access application being made and granted at director level, however, this will be moving on to RiO soon.

Sheila Smith advised that a short life working group is currently looking at grounds access and getting forms on to RiO but this is not progressing as quickly as it should be. A suggestion has been made to set up a grounds access committee that all proposals will go to.

Lindsay Thomson advised that there are wider issues with the work of the clinical model and culture, leadership and management group; one issue that will be pursued is about responsibility and how we get solutions and drive things forward without everything needing to go to Director level to push something forward.

Mark Richards expressed his disappointment at the feedback relating to grounds access; upon reviewing the Learning from Feedback report last month, it was noted that there were a number of outstanding actions, one of which was in relation to grounds access and another related to the need for a short life working group to be over a small number of months not over a year.

Lindsay Thomson will ask the short life working group for an SBAR in relation to grounds access to the next clinical governance group.

Action: Lindsay Thomson

Nicholas Johnson asked for an update for the next meeting on clinical outcomes monitoring; this can either be a verbal report or a one page paper advising the Committee on whether we are getting the engagement we are hoping for.

Action: Gordon Skilling

Lindsay Thomson advised that this is a significant piece of work and the biggest stumbling block is getting it on to the tableau system as we know what the solution is and that is what we need to work towards progressing; immediacy would improve this.

Gary Jenkins advised that work is being done to reprioritise all the work that the IT team do; this is being led by Robin McNaught and the Tableau system should be flagged to him as a priority.

Action: Gary Jenkins

David McConnell thanked Gordon Skilling for the informative report, which was noted and supported going forward.

Dr Gordon Skilling left the meeting at this time.

7 PSYCHOLOGICAL THERAPIES SERVICE 12 MONTHLY REPORT

Members **received** and **noted** the Psychological Therapies Service 12 Monthly Report presented by John Marshall, Head of Psychological Services.

The report contained case vignettes and case studies, which the Committee found to be useful.

Terry Currie asked if the Clinical Outcomes in Routine Evaluation measure (CORE) was something we have developed to do within the State hospital or if it had been brought in from elsewhere. John Marshall advised that this is a widely used measure in health services generally but work is required to unpick the CORE, particularly around insight as patients may not be distressed when they start attending but some become more distressed as they go through therapies. Lindsay Thomson informed the Committee that it is a requirement of the Scottish Government that we use this measure but it is open to us to make a point of debate with them on this issue and ask if we

can do something different. We will need to work out what we could do to show the measure of distress in relevant cases.

John Marshall advised that a Doctoral Trainee Psychologist is undertaking research on CORE and will be gathering data to look at trends.

Mark Richards asked for the reasons behind the small numbers undertaking CBT for Psychosis. John Marshall advised that interventions are delivered routinely and therapies will incorporate elements of CBT for Psychosis which is a manualised approach and there is a view that we should be delivering more. Lindsay Thomson advised that we are seeing fewer patients doing CBT because they are doing mentalisation based work.

Monica Merson asked about the delivery of the healthy living group in each hub which is on Page 19 of the report and what this would be replaced with. John Marshall advised that staff felt it could be delivered simultaneously but found it to be too challenging to deliver that way due to the number of facilitators, back up facilitators and assistant psychology health trainees required to deliver the groups. ID delivery was the focus last year and the healthy living group had to be redesigned for the ID population, which took approximately 4 months to deliver as opposed to a number of weeks for non ID patients.

The Committee noted the report.

8 CLINICAL GOVERNANCE GROUP 12 MONTHLY REPORT

Members **received** and **noted** a report by Lindsay Thomson, Medical Director on the work undertaken by the Clinical Governance Group over the last 12 months.

11 meetings took place in 2019.

There are 26 areas of work set out in the report, all in relation to quality improvement. We are guided by national standards and guidelines and required monitoring reports.

Issues highlighted to the Group include:

- Patient day
- Clinical model
- Work on Intellectual Disability
- Health and wellbeing plans
- Triangle of Care
- Sharing intelligence reports. There are 6 external bodies that report on our work, and this gives us great deal of assurance about our governance and issues within the Hospital

Work is being undertaken around digital inclusion to enable patients to access information using technology as we can no longer say we cannot provide access.

There are 4 areas of priority:

- Clinical model
- Supporting healthy choices
- Patient activity day
- QI and realistic medicine.

Nicholas Johnson asked how many of our patient population are using or could use the sexual harm service. Lindsay Thomson advised that there is an international issue around this service as some programmes with sexual offenders can make them worse and John Marshall is leading on this for us. John Marshall informed the Committee that there is a significant piece of work being

undertaken looking at current literature in high security in particular. We have 4 or 5 patients who require sexual harm input; they will receive or are receiving input from individual clinicians based on CBT approaches. There is no significant change in delivering the service, however, we need to move more towards more individual work and describe what that might look like.

Terry Currie stated that he was surprised to see comments about the Patient Day in relation to staff requiring clarity about what was expected of them given the consultation that had taken place; he asked where we are with this and if it was to be subsumed within the clinical model work and whether it was still a priority. Lindsay Thomson responded by stating that this is an absolute priority and has been partially implemented; this is very much part of the clinical model work and there is much to learn from this. We are currently awaiting guidance from the Clinical Delivery Clinical Guidance Group on how we use the Skye Centre more efficiently and have it more accessible. Mark Richards added that we could not close wards due to patient mix as consistently as we would have liked but he is confident the new clinical model will provide a way of working consistent with how it was originally envisioned.

The Committee noted the report.

9 FORENSIC MEDIUM AND HIGH SECURE CARE STANDARDS – ACTION PLAN

Members **received** and **noted** the Forensic Medium and high Secure Care Standards – Action Plan, presented by Sheila Smith, Clinical Effectiveness Facilitator.

37 actions were assigned to the hospital following the peer review visit:

- 11 high graded actions
- 15 medium graded actions
- 11 low graded actions

There are currently:

- 3 high graded actions which should be taken forward within the next month or so
- 4 medium graded actions
- 3 low graded actions

Terry Currie stated that he was pleased to see the progress made

David McConnell advised that intended timeframes require to be updated.

Action: Sheila Smith

The Committee noted progress to date.

10 SAFE STAFFING REPORT

Members **received** and **noted** the Safe Staffing Report, formerly reported as the Ward Closures Report, for the quarter October to December 2019, presented by Mark Richards, Director of Nursing and AHP.

Mark Richards advised that there are currently 17 Registered Nurse vacancies and sickness absence remains a challenge.

There were 3 occasions in October, 6 in November and 6 in December where staff could not be released. On all occasions modifications were made to care delivery to ensure there were no ward closures.

Brian Paterson has been asked to include a paragraph on whether groups were delivered during staff shortages and provide more detail on the impact of that and also if there were other unmet care needs; Brian is considering how this can be captured and detailed in future reports.

Action: Brian Paterson

5 Registered nurses took up post on 13 January 2020.

A daily "huddle" type review activity takes place to ensure we maintain safe staffing within the Hospital.

Terry Currie referred to page 1, third paragraph, and stated that all Boards had been instructed by the Cabinet Secretary to discontinue any zero hours contracts. Mark Richards advised that the terminology used in the report was incorrect and he will ensure future reports to not make reference to this.

Monica Merson advised that there was a discrepancy in the number of DATIX reports for Q3 (23) and the number contained within the report (15). Sheila Smith advised that she will look into this with Stuart Dick to ensure information is accurate.

Action: Sheila Smith

Nicholas Johnston asked if the number of vacancies referred to in page 2 of the report is flagging up a potential risk. Mark Richards advised that there is an expectation that there will be funding available in the next financial year for 60% registered nurses and 40% unregistered nurses.

The Committee noted the report.

11 LEARNING FROM FEEDBACK

Members **received** and **noted** a report on Learning from Feedback which was presented by Mark Richards, Director of Nursing and AHPs for the period 1 October to 31 December 2019.

89 pieces of feedback were received during the reporting period

72 compliments were received relating to the Skye Centre Festive Lunches.

6 items related to the patients' meal service.

The Patient Partnership Group contributed to 1 Policy Consultation regarding patient property.

Managing visitors and a carer expressing concern about being late for a visit remain concerns.

General suggestions and comments are included in the report around broken treadmills, withholding of newspapers, using side rooms for exercise.

Issues raised at the Patient Centred Improvement Steering Group include:

- Internet shopping, which was identified as an action some time ago has still not been delivered and there is concern that it has taken so long from action to delivery
- Access to the shop - a paper to discuss some proposals around changing access will be presented to the Senior Management Team.
- Progress has been made on the issue of fresh fruit and a paper will be presented to the Senior Management Team in March on how we will achieve a sustainable solution to this.

The Committee noted the report.

12 LEARNING FROM COMPLAINTS

Members **received** and **noted** a report on Learning from Complaints which was presented by Lindsay Thomson, Medical Director for the period 1 October to 31 December 2019.

- 12 new complaints were received in this quarter;
- 8 complaints were submitted by the carers of 2 patients;
- 8 complaints received related to Iona 2;
- Staff Attitude/Behaviour/Conduct accounted for the majority of issues raised;
- 10 complaints were closed in this quarter;
- 3 complaints were resolved at Stage 1;
- 4 complaints were escalated to Stage 2;
- No complaints were upheld in this quarter;
- 1 complaint was partially upheld and 8 complaints were not upheld

The Committee noted that:

- The average time taken to respond to a complaint at Stage 1 was 2 days, similar to the previous quarter;
- The average time taken to respond to a complaint at Stage 2 was 24 days, an increase from 16 days in previous quarter;
- The average time taken to respond to a complaint at stage 2 following escalation, was 16 days compared to 19 days in the previous quarter;
- No new complaints were escalated to the SPSO in this quarter;
- Once complaint under consideration by SPSO has been closed without going to investigation;
- There are currently no other complaints being considered by SPSO.

The Committee noted the report.

13 INCIDENT REPORTING AND PATIENT RESTRICTIONS

Members **received** and **noted** a report on Incidents and Patient Restrictions which was presented by Lindsay Thomson, Medical Director and provided an overview of activity of incidents and patient restrictions for the period from 1 October until 31 December 2019.

- PAA activations have increased during this quarter due to high level of clinical activity;
- 3 patients were attending Wishaw University Hospital for ECT. 2 patients attend twice a week;
- The number of times when handcuffs were used is similar in numbers between Q2 and Q3 due to patients attending ECT appointments. During Q3 the numbers were decreasing by December as 2 of the patients were taking handcuffs but they were not being used;
- During Q3 there has been a higher number of PAA call activations and patient restraints. This is due to higher level of clinical activity in Iona and Lewis.
- No High graded incidents were recorded during the quarter;
- The number incidents reported during the quarter remained similar with a reduction 316 to 301.
    - *Behavioural*' incidents decreased from 72 to 61;
    - '*Verbal Aggression*' incidents increased from 25 to 32;
    - Sexual – Significant reduction in incidents reported decreasing from 10 to 1;
    - '*Assaults*' remained similar decreasing from 5 to 4;
    - '*Slip/Trip/Fall'* – Staff/Other increased significantly from 5 to 11;
    - *'Other'* – Increased from 1 to 6;
    - *'Fire Alarm Activation'* - increased from 0 to 2;

- *Self-Harming Behaviour*' incidents increased from 12 to 17;
- '*Staff Resource'* incidents reported decreased from 66 to 23.
- 'Clinical Waste' incidents reported has decreased from 22 to 9.
- 'Equipment Malfunctions' increased significantly from 7 to 24

There were 3 medication prescribing or supply incidents during the reporting period.

Work is ongoing to address timescales around CAT 1 and CAT 2 reviews.

There were 2 patients secluded over the quarter resulting in a total of 2 seclusions. This matched the last quarter.

The Committee noted the report.

David Walker joined the meeting at this time

14 VISIT EXPERIENCE

Members **received** and **noted** a report on the Visit Experience, presented by David Walker, Security Director.

David Walker advised that, following the CQIF review in 2018 which highlighted several issues with the visitors experience at the State Hospital, a short life working group was established and highlighted the following areas to be addressed:

- Visitors booking system
- Time taken to get carers to ward / Skye Centre
- Creation of a dedicated visiting area
- Improve communication with carers

The actions taken to date are:

- Carer transport, which can carry 8 visitors, will leave at 1350 to take visitors to wards. They are unable to go before then due to shift changeovers.
- From 30 March 2020 there will be a new single point of contact booking system implemented
- Person Centred Improvement Advisor will provide input within the Carers' Reception to coincide with visits, with a view to providing a triage service to seek ongoing feedback in relation to the visit experience
- A new visitor information pack has been developed which includes a section in relation to visiting
- Person Centred Improvement Advisor now receives notification of newly approved visitors and visits booked to enable early contact to discuss visiting processes and clarify any issues / needs which can be resolved in advance to speed up access

Improvement proposals were included in the report for further consideration:

- Delay evening meal times to 1730 – this will provide increased flexibility at the end of the visit if carers arrive after 1400. This may require a service review.
- Having a dedicated visiting area. This proposal is on hold pending developments on the new clinical model.
- Purchase of an electric vehicle to reduce delays in transporting carers around the site
- Person Centred Improvement Team developing a visitor "what matters to you" booklet. This could prevent delays arising at reception due to poor communication

- Visitor items to be retained at reception and delivered post visit. This will reduce the amount of time taken to process carers.

Terry Currie advised that 8 DATIX incidents around the visit experience have been reported since 2013 but he is of the view that the problem is much bigger than these numbers suggest. Mr Currie also advised that the issue is not just around carers it is about visitors in general taking too long getting from reception to where they are going to. Mr Currie suggested that the change be around the culture of getting people to understand that getting people from reception to where they have to go is a priority.

David Walker advised that there is a need to look at an improvement process and he is looking at having a single point of contact and single e-mail address could help the process.

The Committee would like to have an update for the August meeting, post implementation, when Leanne Tennant from the Person Centred Improvement Team has been based within the Carer Centre and a booking system has been established and data is obtained around the time visitors are arising.

Action: Leanne Tennant

The Committee noted the report.

David Walker left the meeting at this time

15 DISCUSSION ITEM
TRIANGLE OF CARE

It was agreed that this item be deferred to the next meeting on Thursday 14 May 2020.

Action: Jacqueline McDade

16 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

Areas of good practice to be added to the log of good practice / areas of concern are around the work of the following:

Mental Health Practice Steering Group
Psychological Therapies Service
Clinical Governance Group

The Committee agreed that the use of vignettes within reports was good practice.

An area of concern is the visitor experience and the improvements going forward.

Action: Jacqueline McDade

Nicholas Johnston expressed concern around clinical outcomes and hubs not engaging in the process. Lindsay Thomson advised that there is a need to resolve technological issues in order to provide information to the wards using Tableau. Lindsay Thomson will have a discussion with the Co-Chairs of the Mental Health Practice Steering Group and an update will be provided at the next meeting.

Action: Lindsay Thomson

17 WORKPLAN

The Committee **noted** the Clinical Governance Committee Workplan.

Triangle of Care to be moved to the next meeting.

Clinical Model to be added as a standing agenda item for a verbal update.

Action: Jacqueline McDade

18 ANY OTHER BUSINESS

Clinical Model Oversight Board

Monica Merson advised the Committee that the Clinical Model Oversight Board met on 27 January 2020. 6 workstreams have been established and are working towards levels of activity.

The Clinical Delivery Guidance document will be presented in draft format to the Clinical Delivery Group, who will then consider a plan for wider consultation across hubs to obtain feedback prior to document being finalised.

The next Clinical Model Oversight Board meets on 25/2/20.

19 DAY, DATE, TIME AND VENUE FOR NEXT MEETING

The next meeting will be held on 14 May 2020 at 9.45am in the Boardroom.

The meeting concluded at 12.15pm

Paper No. 20/31

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 20
Agenda Reference:	Item No: 12
Sponsoring Director:	Interim Human Resources Director
Author(s):	Interim Human Resources Director
Title of Report:	Annual Report of the Staff Governance Committee 2019/20
Purpose of Report:	For Decision

1 SITUATION

The attached Staff Governance Committee Annual report outlines the key achievements and key developments overseen by the Committee during 2019/20. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

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

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

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

3 ASSESSMENT

In the performance year 2019/20, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership.

4 RECOMMENDATION

Members of the Board are asked to note and agree the Staff Governance Committee Annual Report.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE ANNUAL REPORT

1 April 2019 – 31 March 2020

1. INTRODUCTION

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

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

In the performance year 2019/20, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership. Members of the Staff Governance Committee are appointed annually by the NHS Board. Membership details of the Committee during 2019/20 are detailed below.

2. COMMITTEE CHAIR MEMBERS AND ATTENDEES

Committee Chair:
Bill Brackenridge (Chair of Committee, Non Executive Director)

Committee Members:
Nicholas Johnston (Non Executive Director)
Maire Whitehead, Non-Executive Director [to 29 February 2020]
Mr Brian Moore, Non-Executive Director [from 1 February 2020]
Tom Hair (Employee Director)

Ex-officio Members:
Terry Currie (Chair)
Gary Jenkins (Chief Executive)

In attendance:
Kay Sandilands / Elaine Anderson (Interim Human Resources Director) [to 31 March 2020]
Monica Merson (Head of Corporate Planning and Business Support)
Donald Speirs (Lay Representative, Royal College of Nursing)
Anthony McFarlane (Lay Representative, UNISON)
Brian Paterson (Clinical Operations Manager)

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

3. MEETINGS DURING 2019/20

During 2019/20 the Staff Governance Committee met on four occasions, in line with its terms of reference (Appendix 1). Meetings were held on:

23 May 2019
29 August 2019
28 November 2019
20 February 2020

4. REPORTS CONSIDERED BY THE COMMITTEE DURING THE YEAR

The Committee received reports and monitored areas as follows:

- Staff Governance Standard National Annual Monitoring Return 2018/19
- Monitoring of Personal Development Planning & Review (PDPR) performance
- Equality Diversity and Human Rights Workforce Annual Monitoring Report 2018/19 (reported bi-annually)
- Monitoring of Attendance Management performance
- Monitoring HR Performance – Employee Relations Activity
- Everyone Matters: 2020 Workforce Vision: Staff Governance Action Plan
- Monitoring the content and actions relating to Audit Reports covering Staff Governance matters
- Monitoring the content and actions relating to Clinical Governance reports covering Staff Governance matters
- Monitor the update of iMatter, the NHS Scotland Staff Engagement Tool
- Healthy Working Lives (HWL) Annual Update for 2019
- Corporate Risk Register HD111; Deliberate Leaks of Data
- Principles of the Sturrock Review

4.1 ANNUAL REPORTS

Staff Governance Monitoring 2018/19

The Scottish Government reviewed their approach to Staff Governance Monitoring with a view to making the process more dynamic and proactive. The Scottish Workforce and Staff Governance (SWAG) Committee agreed to adopt a more blended approach to Staff Governance monitoring and considered local peer and national information with Boards working collaboratively to identify and drive improvement as well as providing peer support where necessary.

For 2018/19 there was a more tailored Monitoring Template that provided a picture and overview of the progress made in delivering the Staff Governance Standards. Focus continued on the 5 individual strands of the Staff Governance Standards together with Culture and Values and Staff Experience.

Everyone Matters: 2020 Workforce Vision Implementation Plan for 2018/20

The Everyone Matters: 2020 Workforce Vision Implementation Plan for 2018/20 required NHS Boards to deliver on a series of priorities and to embed the NHSScotland shared values. The overall focus of the plan is based on five priority areas with a particular focus during 2018/20 on:

- Embedding iMatter as a continuous improvement tool to improve staff experience with a particular focus on responding to feedback, improving leadership visibility and staff engagement.
- Taking action to promote health, wellbeing and resilience.
- Working across organisational and professional boundaries to share good practice in learning and development, evidence-informed practice and organisational development.
- With our partners, developing workforce planning capacity and capability in the integrated setting.
- Delivering actions within the overview paper "Executive Level Leadership and Talent Management in the NHS in Scotland" (published May 2017).

Boards were also urged to continue their work on the priorities of previous years.

Actions being taken forward during 2020-21:

- ***(Healthy Organisational Culture):*** The Values and Behaviours Group met regularly however the decision was taken to suspend this group while the newly created Culture, Values, Behaviours and Leadership workstream – reporting to the Clinical Model Oversight Board - carries out its remit.
- There was an emphasis on improving staff engagement and supporting a healthy work-life balance. During 2019 the Excellence Awards were set up and several staff and volunteers were publicly recognized for their excellent practice in a number of key areas.
- iMatter continued to be embedded as a continuous improvement tool focusing on improving staff experience.

- ***(Sustainable Workforce):*** A number of groups/departments have been instrumental in supporting the organisation through challenging times. Among these were the Transition Group and the Sustainability & Transformation Group (2018-19). Currently, Corporate Planning & Business Support, HR, Healthy Working Lives and the work streams of the Clinical Model Oversight Board are focused on facilitating the smooth working of the organisation in terms of workforce, processes and model of care

- ***(Capable Workforce):*** Over the past two years, the organisation has continued to deliver on its annual learning plan underpinned by OD. It has provided in-house leadership development opportunities for staff, encouraged the uptake of external opportunities through Project Lift, invested in the PDPR process and Turas appraisal system, shared stories of positive learning experiences through the iMatter process both locally and nationally, as well as encouraging a collegiate approach to learning through initiatives like the Excellence Awards and TSH 30:30.

- ***(Workforce to deliver integrated services):*** National work to support more effective collaboration between national and regional NHS Boards is fully supported by The State Hospital. Collaborative working with other national boards to develop joined-up approaches has continued in a number of key areas e.g. leadership development,

OD plan (*Changing to Deliver*), HR (SLA with Lanarkshire ceased at the end of March 2020), coaching, procurement. The organisation already works closely with other Boards to deliver some essential services e.g. primary care and social work.

- ***(Effective leadership and management):*** Over the past few years, there has been significant leadership development across the organisation, with a particular emphasis on initiatives such as Project Lift, and related development programmes i.e. 'New Horizons' programme (programme for leaders and managers), Leading for the Future (programme for senior leaders), Leadership Cubed (programme for aspiring directors), access to executive coaching.
- We also deliver in-house development opportunities: in addition to an annual programme of statutory and mandatory training, we provide a varied range of opportunities including ILM opportunities for supervisors and team leaders as well as programmes for Band 7 leaders, practice development opportunities, Managing Difficult Conversations, QI essentials, HR core modules for managers, SVQs, individual and team coaching, access to the Board Assessment Tool, psychometrics and 360 degree appraisal, modules in physical health and wellbeing, bursaries. We are currently planning clinical leadership development aimed at Band 6 and 7 clinical leaders.
- More recently, the Culture, Values, Behaviours and Leadership work stream has agreed to support the creation of a sustainable improved leadership and development model for The State Hospital.

Occupational Health Service Annual Report

The annual report was presented to the November 2019 meeting by the Occupational Health Clinical Team from SALUS, the current provider of the OHS service level. Key priorities were highlighted and discussed at length, including:

- Competence of OH staff
- Quality systems, processes and advice
- Service provision including EASY
- Key Performance Indicators
- Measures of performance
- Reducing Absence
- Cost

Healthy Working Lives Annual Report

The annual report was presented at the August 2019 meeting, where members of the Committee noted the work of the Healthy Working Lives (HWL) Group as being exceptional and comparing well to other NHS Boards. Of particular note was retention of Gold Award status since it was achieved in 2008. Continued funding was seen as being important in supporting the HWL Group.

4.2 PROGRESS UPDATES

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

- Personal Development Planning & Review (PDPR)
- Attendance Management
- HR Performance – Employee Relations Activity

PDPR, Personal Development Plan

Monitoring of completion rates for the Personal Development Planning & Review process was kept under scrutiny throughout the year and reported monthly to the Senior Management Team and Partnership Forum. The average monthly completion rate for 2019/20 was 85.9% - an improvement of 14.3% when compared to the previous year.

Attendance Management

Although the State Hospitals Board for Scotland did not achieve the absence management target of 5% in 2019/20, the end of year average monthly absence percentage was 5.74%. This represents an improvement of 2.78% from the 2018/19 figure of 8.52%.

The principal reasons for absence remained consistent with the previous year, with the two most common reasons for absence being anxiety/stress/depression and musculoskeletal conditions.

As previously stated, the Committee paid particular attention and applied more scrutiny to this issue throughout the year in order to be assured that all steps were being taken to reduce the level of absence being experienced.

The Staff Governance Committee recognised the achievement in reducing sickness absence and thanked everyone involved for their efforts.

HR Performance – Employee Relations Activity

These reports continue to be presented for information and discussion due to the historic time delays experienced with HR cases.

The Committee discuss the improvements made from previous years, particularly around compliance with policies. This continues to be a focus for the Committee.

Principles of Sturrock Review

In response to the report to the Cabinet Secretary for Health and Sport into cultural issues relating to allegations of Bullying and Harassment in NHS Highland that was carried out by John Sturrock QC, a programme of work was established to take forward the following themes within The State Hospital: Communications and Engagement, Leadership and Management, Human Resources, Culture and Behaviours, Staff Support and Governance.

This included a staff survey, results of which formed a presentation that was discussed at various meetings and then rolled out to staff through focus groups led by Heads of Departments. The feedback and learning from the meetings and focus groups has since been incorporated into the Culture, Values, Behaviours and Leadership workstream, led by the Chief Executive.

4.3 STANDING ITEMS CONSIDERED BY THE COMMITTEE DURING THE YEAR

Fitness to Practise

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

Everyone Matters: 2020 Workforce Vision

Work continued around the five priority areas previously outlined. Particular attention was given to implementation of Long Service and Staff Excellence Awards. These have not been recognised before and members felt these were areas of importance that should be celebrated.

Both initiatives were very well received across the organisation.

Values and Behaviours Group

Over the past year, The State Hospital has continued to promote the core values of NHSScotland by putting the focus on visibility of values, staff recognition and how we recruit and develop our staff. With the development of the new clinical model, however, this group has now been integrated into the Culture, Values, Behaviours and Leadership sub-group of the Clinical Model Oversight Board. This refreshed group has published its remit and although currently paused due to the Coronavirus pandemic, will resume progress after the current crisis abates.

Healthy Working Lives Group – HWL

This multi-disciplinary group continues to support work around health and wellbeing across the organisation through the delivery of a varied programme of events and initiatives.

The priority areas identified at the annual planning workshop for 2020-2021 are:

- Mental Health – this area has a high impact on stress levels and morale and can have a negative impact on staff attendance.
- Musculoskeletal & Physical Health –we need our workforce to be fit for work and this is a commonly cited cause of absence.
- Health, Safety and Wellbeing – a happy workforce is an engaged workforce. HWL supports the provision of a number of activities throughout the year that help enhance the work environment. One aspect of this work relates to supporting the Culture, Values, Behaviours and Leadership work stream for the refreshed clinical model.

The current Covid-19 pandemic has meant that the submission of the annual national report has had to be put on hold and, at present, members of the group are helping to support other initiatives across the organisation.

Statutory and Mandatory Training

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

Corporate Risk Register HD111: Deliberate Leaks of Data

The Committee receives these reports further to the Finance, Risk and Performance Committee requesting that Governance groups/committees routinely review the risks in their scope that are categorised as high, ensuring that the Governance Committee has oversight of the risk, an opportunity to review control measures and identify any further actions/controls that may further mitigate the risk.

Notes of Minutes from other meetings

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

- Partnership Forum
- Health and Safety Committee
- Clinical Governance papers (as appropriate and where related to a Staff Governance issue)

5. CONCLUSION

The performance year 2019/20 has underlined the continuing need to focus our attention on key Staff Governance issues.

The main priority area in terms of Staff Governance performance management continues to be the pursuit of the Attendance Management target of 5% absence.

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

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee's behalf during 2019/20**.**

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE
TERMS OF REFERENCE

1 PURPOSE

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

2 COMPOSITION

2.1 Membership

The Staff Governance Committee is appointed by the Board and shall be composed of the Employee Director and three other Non-executive Board Members one of whom shall act as Chair.

The Chairperson of the Board, and the Chief Executive, shall both be ex-officio members.

There will be three lay representatives identified by the staff side organisations and nominated by the Partnership Forum. The lay representatives will not act in an ex officio capacity.

An ex-officio member is a member of a body who is part of it by virtue of holding another office. Such members shall have the power to vote in the Committee's decisions.

Membership will be reviewed annually.

The Staff Governance Committee will have the authority to co-opt other attendees from outwith the Board in order to carry out its remit.

2.2 Appointment of Chair

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

2.3 Attendance

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

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive) and Human Resources Director shall be invited to attend meetings and receive all relevant papers. Other Directors and staff may also be invited by the Chair of the Committee to attend meetings as required.

3 MEETINGS

3.1 Frequency

The Staff Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken. The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Human Resources Director.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Board meeting. A personal assistant is responsible for minute taking arrangements.

Minutes of the Staff Governance Committee will be presented to the next Staff Governance Committee meeting for approval and to ensure actions have been followed up. These are presented to the Board for their information.

The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive prior to submission to the Board.

3.5 Other

In order to fulfil its remit, the Staff Governance Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

4 REMIT

4.1 Objectives

The main objectives of the Staff Governance Committee are to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital; and that the principles of the national Staff Governance Standards and The State Hospital's Staff Charter are applied equitably and fairly to all staff.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with staff governance standards, in delivery of improved working arrangements for

staff, and ultimately in achievement of outcome targets as evidenced through the staff related key performance indicators reported in the Local Delivery Plan.

4.2 Systems and accountability

4.2.1 To ensure that appropriate staff governance mechanisms are in place throughout the hospital in line with national standards.

4.2.2 To ensure that people management risks are managed in accordance with the corporate risk management strategy, policies and procedures.

4.2.3 To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed.

4.2.4 To review the Staff Governance Action Plan and ensure that the Partnership Forum is performance managing the action plan.

4.3 People management

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

4.3.1 Culture is maintained within the hospital where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the hospital and is built upon partnership and collaboration.

4.3.2 Structures are in place to monitor the outcome of strategies and implementation plans relating to people management.

4.3.3 Structures are in place to monitor the outcome of strategies and implementation plans relating to knowledge management.

4.3.4 Propose policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.5 Support is given for any policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.6 There is timely submission of all staff governance data required by the Scottish Government Health Department and in respect of the Annual Operating Plan.

4.3.7 Pay modernisation processes are monitored and that the Boards Pay Benefits Realisation Plans are signed off.

4.3.8 Workforce planning and development is monitored and to sign off the Boards Workforce Plan and the Boards Development Plan and ensure they support the Local Delivery Plan.

4.3.9 Policies and procedures are developed, implemented and reviewed.

4.4 Controls assurance

To ensure that:

4.4.1 The information governance framework provides appropriate mechanisms for Codes of Practice on Data Protection and Freedom of Information to be applied to all staff.

4.4.2 The planning and delivery of services has fully involved partnership working.

4.4.3 Systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.

4.4.4 Staff governance information is provided to support the statement of internal control.

5 AUTHORITY

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

The Committee is authorised to establish a Remuneration Committee to cover staff under executive and senior manager pay arrangements and to validate the work of that committee. The Remuneration Committee must include, as a minimum, three non executive Directors of the Board. The Remuneration Committee will be a closed committee and shall sign off its own minutes. The Staff Governance Committee will require to be provided with assurance that systems and procedures are in place to appropriately manage the pay of this group of staff. This will not include detailed confidential employment issues that are considered by the

Remuneration Committee: these can only be considered by non executive Directors of the Board.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance and effectiveness in meeting the terms of reference; including its running costs, and level of input of members relative to the added value achieved
- Proposed changes, if any, to the terms of reference.

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Staff Governance Committee, by presenting the minutes of the Committee for approval.

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

8 COMMUNICATION AND LINKS

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

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

Paper No. 20/32

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2020
Agenda Reference:	Item No. 13
Sponsoring Director:	Interim Human Resources Director
Author(s):	Interim Human Resources Director
Title of Report:	Annual Report of the Remuneration Committee 2019/20
Purpose of Report:	For Decision

1 SITUATION

To provide a report containing a summary of the work overseen by the Remuneration Committee. The attached Remuneration Committee Annual report outlines the key achievements and key developments overseen by the Committee during 2019/20. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

The Staff Governance Standard sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met and that all policies and agreements are implemented**.**

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

- A review of the committee's work programme for forthcoming years.
- A review of the committee's terms of reference. An annual report summarising the work of the remuneration committee.

3 ASSESSMENT

This report outlines the work of the Remuneration Committee as it seeks to support the State Hospitals Board for Scotland's aim to be an exemplar employer with systems of corporate accountability for the fair and effective management of all staff, with particular regard to the pay, performance and terms and conditions of Executive and Senior Managers.

The Remuneration Committee reports to the Board. The committees Terms of reference are subject to annual review. The programme of work is largely determined by the requirement to implement executive and senior managers pay with reference to relevant SGHD instruction and performance appraisal. In addition oversight of the application and award of discretionary points is a routine consideration of the committee as is consideration of ad-hoc issues relating to remuneration.

4 RECOMMENDATION

Members of the Board are asked to agree the Remuneration Committee Annual Report.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE ANNUAL REPORT

1 April 2019 – 31 March 2020

1 INTRODUCTION

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

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

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

In the performance year 2019/20, The State Hospitals Board for Scotland's Remuneration Committee continued to focus its monitoring activities in respect of the above, with particular regard to the performance, pay and terms and conditions of Executive and Senior managers.

2 COMMITTEE CHAIR MEMBERS AND ATTENDEES

Committee Chair:
Terry Currie, NHS Board Chair

Committee Members:
Maire Whitehead, Non-Executive Director [to 29 February 2020]
Bill Brackenridge, Non-Executive Director
Nicholas Johnston, Non-Executive Director

Tom Hair, Employee Director
Mr David McConnell, Non-Executive Director
Mr Brian Moore, Non-Executive Director [from 1 February 2020]

In Attendance:
Gary Jenkins, Chief Executive
Kay Sandilands, Interim HR Director (part year)
Elaine Anderson, Interim HR Director (part year)
Margaret Smith, Board Secretary

3 MEETINGS DURING 2019/20

During 2019/20 the Remuneration Committee met on three occasions, in line with its terms of reference. Meetings were held on:

- 20 June 2019
- 22 August2019
- 19 December 2019

4 REPORTS CONSIDERED BY THE COMMITTEE DURING THE YEAR

- Approval of the Performance Management arrangements and Performance Appraisals for Executive Directors for the performance year 2018-19.

- Agreement that the Appraisal outcomes for Executive Directors be submitted to the National Performance Management Committee. Also consideration of the National Performance Management Committee's appraisal analysis.
- Agreement of the Executive Directors Performance Planning and Review (Objectives) for the year 2019/20.
- Consultants discretionary points were reported on and approved.
- Approval of Executive and Senior Managers Pay for 2018-19.

5 CONCLUSION

The Remuneration Committee discharged its responsibilities with regard to the oversight of Executive and Senior Managers' performance management and remuneration. The Committee also reviewed a range of other issues as required during the reporting period.

I would like to thank the Committee members for their contribution to the meetings in 2019/20.

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE

TERMS OF REFERENCE

TITLE

1 The Committee shall be known as the Remuneration Committee of The State Hospitals Board for Scotland. It will be a standing Committee of The State Hospitals Board for Scotland and will make decisions on behalf of The State Hospitals Board for Scotland.

COMPOSITION

2 The Remuneration Committee members will be appointed by The State Hospitals Board for Scotland and will consist of:

- The Committee Chair
- The Chair of The State Hospitals Board for Scotland
- All other Non-Executive Directors of the Board, including the Employee Director

In addition there will be in attendance:

- Chief Executive
- Human Resources Director
- Board Secretary

No employee of the Board shall be present when any issue relating to their employment is being discussed.

3 The Human Resources Director will be the Executive Director Lead and will attend meetings of the Remuneration Committee as Advisor. . The Human Resources Director will not be present during discussion of Executive colleagues' appraisals.

Executive Director Lead
Generally, the designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to / in fulfilment of its agreed Terms of Reference. Specifically, they will:

- support the Chair in ensuring that the Committee Remit is based on the latest guidance and relevant legislation;
- liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;
- oversee the development of an Annual Workplan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for endorsement by the Committee and approval by the Board;
- agree with the Chair an agenda for each meeting, having regard to the Committee's Remit and Workplan;
- oversee the production of an Annual Report, informed by self assessment of performance against the Remuneration Committee Self Assessment Handbook, on the delivery of the Committee's Remit and Workplan for endorsement by the Committee and submission to the Board.

4 Where issues with financial implications are to be discussed at the Remuneration Committee the implications will first have been discussed with the Finance Director and, where appropriate, the Finance and Performance Management Director may be invited to attend meetings of the Remuneration Committee.

5 The quorum for the Remuneration Committee will be attendance by 3 Non-Executive Directors, inclusive of the Chair.

FUNCTIONS

6 To oversee and agree the remuneration arrangements and terms and conditions of employment of Executive Directors and Senior Managers of The State Hospitals Board for Scotland, to include:

- content and format of job descriptions
- terms of employment including tenure
- remuneration
- benefits including pension or superannuation arrangements
- annual salary review

7 To ensure arrangements are in place for the assessment of the performance of The State Hospitals Board for Scotland and to monitor the performance of The State Hospitals Board for Scotland against pre-determined performance criteria to inform oversight of objective setting and support for decisions on individual performance appraisal.

8 To agree The State Hospitals Board for Scotland's arrangements for performance management and to ensure that the performance of the Executive Directors is rigorously assessed against agreed objectives within the terms of the performance management arrangements referred to above.

9 To ensure that clear objectives are established for Executive Directors of The State Hospitals Board for Scotland before the start of the year in which performance is assessed by

- receiving a report from the Chair on the agreed Objectives for the Chief Executive
- receiving a report from the Chief Executive on the agreed Objectives for the other Executive Directors of the Board.

10 To monitor arrangements for the pay and conditions of service of other Senior Managers on Executive Pay arrangements and on Professional/Management Transitional pay arrangements in accordance with appropriate guidance and to implement annual pay uplifts and pay progression in accordance with national guidance.

11 To approve The State Hospitals Board for Scotland's arrangements for the grading of Senior Manager and Executive Director posts and to oversee these arrangements by receiving regular reports from the Director of Human Resources.

12 To ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for staff employed under the Executive and Senior Management Pay arrangements. To receive formal reports (at least annually) providing evidence of the effective operation of these arrangements.

13 To consider any redundancy, early retiral or termination arrangement in respect of all State Hospital staff, excluding early retirals on grounds of ill health, and approve these or refer to the Board as the Committee sees fit. In addition the Committee will oversee the award of discretionary points to medical staff.

14 To fulfil its functions, the Remuneration Committee will take into account a range of factors which will include

- regular reports from the Human Resources Director
- the Remuneration Committee Self Assessment Handbook
- guidance issued by the Scottish Government Health Department
- an annual report on the application of pay awards and pay movements
- the need to recruit and retain appropriately qualified and skilled Directors, General and Senior managers
- equitable pay and benefits for the level of work performed

CONDUCT OF BUSINESS

15 Meetings of the Committee will be called by the Chair of the Committee with items of business circulated to members one week before the date of the meeting.

16 The Committee will seek specialist guidance and advice as appropriate.

17 All business of the Committee will be conducted in strict confidence.

REGULARITY OF MEETINGS

18 Meetings of the Remuneration Committee will be held as necessary to conduct its business. At a minimum, the Committee should meet twice per annum, once to approve the performance assessments and annual Objectives of the Executive Directors and once to approve the annual application of pay awards and pay progression.

REPORTING ARRANGEMENTS

19 The Remuneration Committee will report to the Board.

Membership of the Remuneration Committee will be reported to and agreed by the Board. Appropriate details of Executive Members remuneration will be published in The State Hospitals Board for Scotland's Annual Report.

Annual Report
In accordance with Board and Committee Working, the Committee will submit to the Board each year an Annual Report, encompassing : the name of the Committee; the Committee Chair; members; the Executive Lead and officer supports / attendees; frequency and dates of meetings; the activities of the Committee during the year, including confirmation of delivery of the Annual Workplan and review of the Committee Terms of Reference; improvements overseen by the Committee; matters of concern to the Committee.

Where the review by the Committee of its Terms of Reference results in amendment the revised Terms of Reference must be submitted to the Board for approval. The Committee Annual Report will inform the submission of any appropriate assurance to the Chief Executive at the year-end, as part of the Statement of Internal Control.

20 Details of the business conducted by the Committee will be made available to the Scottish Government Health Department, the form and content being determined by the latter.

21 A Report, marked as 'confidential', on each meeting of the Remuneration Committee will be issued to the Non Executive Directors of the Board.

THE STATE HOSPITALS BOARD FOR SCOTLAND

APPROVED Minutes of the meeting of the Staff Governance Committee held on Thursday 20 February 2020 at 9.45am in the Boardroom, The State Hospital, Carstairs. **SG(M) 20/01**

Present:

Employee Director	Tom Hair ***(Chair)***
Non-Executive Director	Nicholas Johnston
Non-Executive Director	Brian Moore

In attendance:

Interim HR Director	Elaine Anderson
Board Chair	Terry Currie
Chief Executive	Gary Jenkins
PA to Human Resources Director	Rhona Preston (minutes)

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Tom Hair welcomed everyone to the meeting and noted apologies from Bill Brackenridge, Monica Merson, Anthony McFarlane, Brian Paterson and Maire Whitehead.

Due to clinical activity on the wards it was recognised that Anthony McFarlane was unable to attend the meeting. There was discussion around future attendance by staff side colleagues with Terry Currie asking Tom Hair to make them aware of their value and contribution at this Committee and as such should be encouraged to attend. Previous meetings have been well attended and the challenging circumstances around recent admissions was noted, however Gary Jenkins will discuss the requirement of permitting facility time with the Clinical Operations Manager to re-emphasise participation at this Committee.

ACTION: T HAIR and G JENKINS

Brian Moore was introduced to the Committee as our recently appointed Dedicated Non-Executive Director Whistleblowing Champion. He advise that both himself and Terry Currie are due to attend a Whistleblowing Training event being held in Glasgow on Friday 28 February, this will provide further clarification around the role. The role of the Independent Whistleblowing National Lead has been introduced following the Francis Report on Mid Staffordshire NHS Foundation Trust and from the Freedom to Speak Out review. This role will form part of the package and will now be the Independent National Whistleblowing Officer (INWO) located at Scottish Public Services Ombudsman (SPSO). As part of the Once for Scotland initiative the Whistleblowing procedures are being reviewed as part of the exercise. This role will enhance openness and transparency and will provide an opportunity to build upon.

Brian Moore confirmed he is a full member of the Board and is fully committed to this and although a Non-Executive Director at NHSL he is confident there are no diary clashes and will undertake all responsibilities here at The State Hospital. He is a retired Chief Officer from Inverclyde and Social Care Partnership where he was located for 6 years. Before that he worked in Social Work in South Lanarkshire Council and would often be here on site as part of this role.

Tom Hair thanked Brian Moore for his introduction and welcomed him to the Hospital.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business to be discussed.

3 MINUTES OF THE PREVIOUS MEETING HELD ON 28 NOVEMBER 2019

The Committee approved the Minutes of the previous meeting held on 28 November 2019 as an accurate record.

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Members noted that the actions listed where on today's agenda or included in the workplan for future meetings.

Health, Safety and Welfare Committee
Gary Jenkins advised that he has discussed with the Chair of the committee David Walker the importance of ensuring these meetings are held regularly with a full quorum. It was agreed a paper will come to the May Staff Governance Committee highlighting a revised terms of reference and redevelopment of the structure for these future meetings.

ACTION: DAVID WALKER

STANDING ITEMS

5 ATTENDANCE MANAGEMENT REPORT

Members of the Committee received and noted the Attendance Management Report to 31 December 2019 as presented by Elaine Anderson, Interim Human Resources Director. It was reported that the 12 month position is 5.89% which is favourable compared to the previous year. Members noted the focus on the downward trend of the rolling 12 months, work is ongoing into this as HR staff are trying to establish whether this is seasonal or not.

The key points throughout the report were highlighted with members being advised of the inaccuracy contained within the EASY reporting section. Elaine Anderson advised this will be amended to reflect the accurate figures being recorded. It has been recognised that there is a difference in the recording of absence between SSTS and EASY, HR Advisors are targeting these issues with the Managers to ensure all recording is tightened.

The improvements over the last year have been steady and it is important to continue the focus on this however it was also noted that December and January can be notorious in terms of additional absences being recorded. Absence patterns has been discussed previously and members are keen that historically these are still looked into in the hope this maintains continued improvement. Elaine Anderson advised that work is underway around this in the areas where concerns have been reported. Members were updated on work being taken forward in relation to long-term absences across Arran and Mull where both are reporting a high number of absences. Gary Jenkins has met with the Head of HR and Clinical Operations Manager to review these cases.

Brian Moore observed the reference made in previous minutes regarding the Attendance Management Improvement Working Group and asked if required, could this be re-established. Gary Jenkins explained that due to the Culture Values and Behaviour workstream that is underway this group would progress with some of the work however, should absence become a challenge then this would be re-visited.

The Committee noted the report.

6 HR PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

Members of the Committee received and noted the Employee Relations Activity Report to 31 January 2020 as presented by Elaine Anderson, Interim Human Resources Director who summarised the report, advising members that during January 2020 there was one new case raised. Tom Hair explained to Brian Moore the background to the requirement of this report was due to a lengthy period of HR staff shortages which resulted in delays with progressing cases.

However it was noted that this is a much improved picture following efforts made by the HR staff and Managers involved.

The timescales noted in the report at appendices 1 and 2 were highlighted and discussed at length. With members being advised that the cases showing as older than 9 months were as a result of delays caused by awaiting additional guidance from STAC together with individual human factors that are causing the delays however it was noted these are being actively managed through the process.

As shown in appendix 1, additional guidance was sought from STAC (Scottish Terms and Conditions), this has resulted in a long time delay however STAC have now contacted all Boards for information therefore it is hoped that this will be resolved in the near future as soon as the guidance is received and will be able to move on.

The lengthy delays shown in appendix 2 are not as a result of HR or Staffside but as a result of individual situations due to external process or sickness absence. Members were advised one is due to a court case pending and another is due to a significant health condition.

There was a lengthy discussion around continuing with processes without the individual in attendance. It is recognised that a focus should be kept on continuing with the process. It may require Occupational Health input and or a discussion with the staff member with support in place.

Letter templates are prepared should agreement be reached in partnership to take forward any cases. However Tom Hair expressed his concern in this process but understands the urgency to keep these cases moving and get them resolved timeously as it is recognised that the delay in these cases can also cause added stress and anxiety to the staff member.

Nicholas Johnston asked that due to this being a smaller Board we should be able to get to the source and rectify this position.

The Committee noted the report and discussion and thanked Elaine Anderson for her update around the reasons associated with the delays.

7 PERSONAL DEVELOPMENT PLAN REPORT

Members of the Committee received and noted the Personal Development Plan Report (PDPR), prepared by Sandra Dunlop, Training and Professional Development Manager.

Members received and noted the PDPR Progress Update. As at Monday 10 February 2020 the total number of current reviews is 530 (89.2%), an increase of 0.4% from the previous report.

- A total of 59 staff (9.9%) have an out-of-date PDP (i.e. the annual review meeting is overdue) – an increase of 0.2% from the previous report. (Please note that in addition to the 59 reviews that are currently overdue, a further 32 reviews are due by 29 February 2020, and 47 by 31 March 2020.)

- The remaining 5 staff (0.9%) currently have no PDPR meeting – a decrease of 0.6% from the previous report. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

As at 10 February 2020 a total of 89.2% of staff met the standard of having a review meeting conducted within the past 12 months.

Elaine Anderson advised members that this report was discussed at length at the SMT on 19 February. Members of the SMT were asked to give a guarantee and provide commitment that all staff members have face to face discussions to ensure this is a meaningful process with all staff being encouraged to actively participate in this important process.

There was discussion around the overdue reviews outlined in appendix 1. Members were given

assurance that discussions had taken place with the Director who has instructed that these are carried out effectively and timeously.

Members noted the report and discussion and asked that focus continues ensuring the quality of this process.

8 CORPORATE RISK REGISTER HD111: DELIBERATE LEAKS OF DATA

Members of the Committee received and noted the Deliberate Leaks of Data, Corporate HD111 as presented by Elaine Anderson, Interim Human Resources Director. This report is now being presented to this Committee further to the Finance, Risk and Performance Committee having requested that Governance groups/committees routinely review risks in their scope that are categorised as “High”. This is to ensure that the Governance Committee has oversight of the risk, an opportunity to review control measures and identify any further action/controls that may further mitigate the risk.

From the actions noted at the November meeting members were advised that these continue to be explored. It was noted however that there have been no further leaks.

Due to the majority of staff being employed for a number of years it was suggested to source a way of ensuring all staff are aware of their obligations around confidentiality, similar to when they commenced their employment. Elaine Anderson agreed to take this forward and will explore meta-compliance.

ACTION: ELAINE ANDERSON

The Committee noted the report.

ITEMS FOR DISCUSSION

9 EVERYONE MATTERS: 2020 WORKFORCE VISION: STAFF GOVERNANCE ACTION PLAN

Members of the Committee received and noted the Everyone Matters, 2020 Workforce Vision update as prepared by Jean Byrne, Organisational Development Manager. The five priority areas outline that continue to be developed are;

- Embedding iMatter as a continuous improvement tool to improve staff experience and particularly responding to feedback, improving leadership visibility and staff engagement.
- Taking action to promote health, wellbeing and resilience.
- Working across organisational and professional boundaries to share good practice in learning and development, evidence-informed practice and organisational development.
- With our partners, developing workforce planning capacity and capability in the integrated setting.
- Delivering actions within the overview paper “Executive Level Leadership and Talent Management in the NHS in Scotland”.

Members of the Senior Management Team received this update at their meeting yesterday and agreed their support.

Brian Moore advised that he had found this report very helpful particularly with taking up his new role this has provided a very good oversight in all the positive work taking place.

Terry Currie explained to the Committee that the decision was taken to focus on implementing the Long Service Award. The Hospital has not recognised this before and it was felt this was an important area that should be celebrated. Also established has been the Staff Excellence Awards. These initiatives have been very well received across the organisation.

The Committee noted the update provided and agreed with the importance of these initiatives.

10 ADVERSE EVENT REPORTING TIMESCALES

Members of the Committee received and noted the Adverse Event Timescale Update as reported as an area of concern at the Clinical Governance Committee.

There have been no Category 1 reviews commissioned during 2019/20. One category 2 review is in the process of being commissioned at the time of this report with draft terms of reference sent out for comment/approval.

The Committee noted the report.

11 STAFF CHARTER

Members received and noted the request for approval to cease the distribution and publication of the Staff Charter as presented by Elaine Anderson, Interim Human Resources Director and Tom Hair, Employee Director. Prior to the Staff Governance Standards being developed for NHS Scotland, the State Hospitals Board for Scotland developed and implemented "This is your Staff Charter: Know your Rights and Responsibilities" which included guidance on Communication, Access to Learning and Appropriate Training, Involved in Decisions that Affect You, Fair and Consistent Treatment and A Safe Working Environment.

The expectations set by the Staff Governance Standard create duplication and supersede the Board's Staff Charter. Existing organisational information relates to both the Staff Charter and Staff Governance Standards.

Members of the Staff Governance Committee are invited to support the recommendation to cease distribution and publication of the staff charter and support the amendment of organisational information to refer to the Staff Governance Standards only.

Nicholas Johnston advised that reassurance will need to be provided to staff with a clear explanation around the reasons for removing the Staff Charter and asked that the standards are highlighted clearly to them.

Members agreed to ratify this decision and asked that this is presented to Partnership Forum for approval and implementation.

ACTION: T HAIR and E ANDERSON

ITEMS FOR INFORMATION

12 THE SCOTTISH GOVERNMENT DL(2020)1: HEALTHCARE ASSOCIATED INFECTION (HAI): GUIDANCE FOR STAFF SCREENING DURING HEALTHCARE ASSOCIATED INFECTION INCIDENTS AND OUTBREAKS

Members received and noted the update from The Scottish Government who want to ensure all NHS Boards are aware of the guidance issued in relation to the Coronavirus.

Additional information will be issued and shared as necessary.

Members noted this guidance.

13 NATIONAL HEALTH AND SOCIAL CARE WORK PLAN

Members received and noted the update from the Scottish Governments workforce planning unit. This was to improve coordinated workforce planning across Scottish Government policy areas associated with the health workforce.

It was noted that the workforce stream here at the Hospital is being addressed through the new Clinical Model.

The Committee noted the update.

14 PARTNERSHIP FORUM – MINUTES OF MEETING HELD 28 NOVEMBER 2019

Members received and noted the Partnership Forum minutes from 28 November 2019. Members were advised that the 24 December meeting did not go ahead due to the number of apologies received prior to the meeting date.

ANY OTHER COMPETENT BUSINESS

15 ANY OTHER BUSINESS

There were no other items of business for consideration.

16 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 28 May 2020 at 9.45am in the Boardroom, The State Hospital, Carstairs.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2020
Agenda Reference:	Item No: 15
Sponsoring Director:	Finance and Performance Management Director
Author(s):	Finance and Performance Management Director
Title of Report:	Annual Report of the Audit Committee 2019/20
Purpose of Report:	For Decision

1 SITUATION

The Report outlined in Appendix 1 is presented to the committee to meet the requirements within the Committee's Terms of Reference to submit an annual report of the work of the Committee to the Board. The report also supports the Governance Statement in providing periodic reports to the Board from the Committee in respect of Internal Control.

2 BACKGROUND

The establishment of an Annual Report by the Audit Committee is an important assurance process to the Board in considering the effectiveness of internal controls.

The report outlines the work of the Committee, including:

- Frequency of meetings
- The activities of the Committee
- Progress in Corporate Governance
- Update Terms of Reference

An effective system of internal control is fundamental to securing sound financial management of the Board's affairs.

The consideration and review of internal and external audit reports, and management responses, together with reports submitted by other officers, assist the Committee in advising the Board with regard to material risks.

3 ASSESSMENT

This report is presented in draft for approval to present to this afternoon's Board Meeting.

4 RECOMMENDATION

The Board is asked to approve the Audit Committee Annual Report for 2019/20.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT COMMITTEE ANNUAL REPORT

1 April 2019 – 31 March 2020

1 INTRODUCTION

The Report is submitted to meet the requirements within the Audit Committee's (the Committee's) Terms of Reference to submit an annual report of the work of the Committee. The report also seeks to satisfy the Governance Statement requirement for the Committee to provide periodic reports to the Board in respect of Internal Control.

2 MEMBERSHIP AND ROLE OF THE COMMITTEE

Audit Committee

Membership	**Role**
D McConnell (Chair) W Brackenridge T Hair M Whitehead (to 29 February 2020)	To oversee arrangements for external and internal audit of the Board's financial and management systems and to advise the Board on the strategic processes for risk, control & governance. It met 4 times during 2019/20.

3 AUDIT

External audit coverage of the Board was provided by Scott Moncrieff.

The Internal Audit service was provided by RSM UK.

4 REVIEW OF THE WORK OF THE COMMITTEE

The Internal Audit Operational Plan from RSM for 19/20 was approved by the Committee at its meeting on 28 March 2019. The plan was kept under review for the remainder of the year.

The plan was designed to target priority issues and structures to allow the Chief Internal Auditor to provide an opinion on the adequacy and effectiveness of internal controls to the Committee, the Chief Executive (as Accountable Officer) and the External Auditors.

During financial year 2019/20, the Committee met on FOUR occasions: 20 June 2019, 10 October 2019, 23 January 2020 and 26 March 2020.

During the period from 31 March 2019 and up to the consideration of the Annual Financial Statements on 18 June 2020, the committee has:

- Received progress reports from the Chief Internal Auditors against the Internal Audit Plans approved by the Committee
- Reviewed audit reports and action plans
- Reviewed progress on action taken by management on action plans
- Reviewed the final Annual Report for 2019/20 from the Chief Internal Auditor
- Received the Annual Report and audit certificate for the 2019/20 audit from Scott Moncrieff
- Reviewed the Standing Financial Instructions, Standing Orders and Scheme of Delegation, and recommended these for approval to the Board
- Reviewed its Terms of Reference
- Review the log of waivers of standing financial instructions.
- Considered the Fraud Incident Log
- Reviewed Counter Fraud Service Alerts
- Reviewed Fraud Action Plan
- Reviewed progress made with the National Fraud Initiative
- Received national Audit Scotland reports and performance audit studies, relating to the Health Service and to the wider public sector
- Met in private with Internal and External Auditors

- Reviewed the recommendations received from National Services Scotland from their service audit reports.
- Reviewed the recommendations received from NHS Ayrshire & Arran from the service audit report on the National Single Instance (NSI) system
- Reviewed the annual reports from the Governance Committees
- Reviewed the Code of Conduct
- Reviewed and approved the Annual Audit Committee Assurance Statement to the Board
- Reviewed the summary of Losses and Special Payments
- Reviewed and approved the Losses and Special Payment Policy
- Reviewed and approved the Patients Funds Annual Accounts for submission to the Board
- Reviewed and recommended approval of the statutory Annual Accounts to the Board
- Submitted minutes of meetings to the Board throughout the year
- Reviewed external Audit Plan
- Reviewed and noted update on Business Continuity Resilience arrangements
- Reviewed the annual report on Risk Management
- Endorsed the Risk Management Strategy
- Received updates from the Human Resources Director in relation to the progress on the Sickness Absence audit report.
- Reviewed and noted the Procurement Strategy and Annual Report
- Reviewed and noted the Corporate Risk Register
- Review and agreed Audit Committee Work Plan 2020
- Reviewed and noted the Policy Management Update
- Received the minutes of the Risk, Finance and Performance Group
- Received a verbal update on the Draft Operational Plan
- Reviewed Category 1 and 2 Annual Update on Outstanding Actions

5 CORPORATE GOVERNANCE

During 2019/20 the Board's Internal Auditors reported on the following significant areas of work:

- Payroll
- Sickness and Absence Management
- Accounts Payable
- Rostering and Scheduling of Workforce
- Clinical Observations
- Follow Up of previous internal audit actions
- Property Transaction Monitoring

Implementation of New Clinical Model audit was moved to 2020/21 reporting period.

Work on Patient Funds / Property Review is delayed due to Covid19 Restrictions.

6 CONCLUSION

Based on the work that it has undertaken, the Committee has met in line with the Terms of Reference, has fulfilled its remit and is satisfied that internal controls are adequate to ensure that the Board can achieve the policies, aims and objectives set by Scottish Ministers, to safeguard public funds and assets available to the Board, and to manage resources efficiently, effectively and economically.

D McConnell
AUDIT COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit Committee
18 June 2020

THE STATE HOSPITALS BOARD FOR SCOTLAND
AUDIT COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Audit Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with assurance in respect of risk, governance and internal control including financial control.

2 COMPOSITION

2.1 Membership

The Audit Committee is appointed by the Board and shall be composed of at least three Non-executive Board members, one of whom shall act as Chair. Membership will be reviewed annually and disclosed in the Annual Report.

2.2 Appointment of Chairperson

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

2.3 Attendance

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive), Finance and Performance Management Director, Chief Internal Auditor, a representative from External Audit and any other appropriate officials shall normally attend meetings and receive all relevant papers. Other Directors may also be invited by the Chair of the Committee to attend meetings as required.

All Board Members will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

Audit Committee members must regularly attend the Committee and if not appropriate action taken.

3 MEETINGS

3.1 Frequency

The Audit Committee will meet at least four times a year to fulfil its remit and shall report to the Board at least twice in each financial year.

The Chair of the Committee may convene additional meetings as necessary.

The accountable officer should attend all meetings but if he/she does not, be provided with a record of the discussions.

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

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Audit Committee meeting, prior to submission to the Board.

Recognising the issue of relative timing and scheduling of meetings, minutes of the Audit Committee may be presented in draft form to the next available Board meeting.

The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive prior to submission to the Board.

4 OTHER

In order to fulfil its remit, the Audit Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee and / or the External Auditor or Internal Auditor. It is expected that this should occur at least once in each financial year.

The Chief Internal Auditor and the representative(s) of External Audit will have free and confidential access to the Chair of the Committee.

The Chair of the Audit Committee should be available at the Board's Annual Accounts Approval Meeting to answer questions about its work.

5 REMIT

5.1 Objectives

The main objectives of the Audit Committee are to provide the Board with the assurance that the State Hospital acts within the law, regulations and code of conduct applicable to it, and that an effective system of internal control is maintained.

The committee periodically assesses its own effectiveness to ensure that the Audit Committee fulfils its remit, this may involve assessing the attendance and performance of each member.

New members receive a suitable induction and declare his/ her business interests.

The duties of the Audit Committee are in accordance with the Audit Committee Handbook, July 2008. http://www.scotland.gov.uk/Publications/2008/08/08140346/

5.2 Internal Control and Corporate Governance

5.2.1 To evaluate the framework of internal control and corporate governance comprising the following components:

- Control environment; Risk management strategy, procedures and risk register;
- The effectiveness of the internal control and risk managements systems
- Decision-making processes;
- Receive and consider stewardships reports in key business areas.
- Information;
- Monitoring and corrective action

5.2.2 To review the system of internal financial control which includes:

The safeguarding of assets against unauthorised use and disposition;

- Maintenance of proper accounting records and

- the reliability of financial information used within the organisation or for publication.

5.2.3 To have a mechanism to keep it aware of topical legal and regulatory issues and ensure the Board's activities are within the law and regulations governing the NHS.

5.2.4 To monitor performance and best value by reviewing the economy, efficiency and effectiveness of operations.

5.2.5 To present an annual assurance statement on the above to the Board to support the Directors' Governance Statement on Internal Control.

5.2.6 To take account of the implications of publications detailing best audit practice.

5.2.7 To take account of recommendations contained in the relevant reports of the Auditor General and the Scottish Parliament.

5.2.8 To review audit reports and management action plans in relation to physical security of the Hospital.

5.2.9 To provide assurance to the Board that plans are in place to ensure service continuity and to provide contingencies for emergency situations.

5.2.10 To provide assurance to the Board that plans and mechanisms are in place to ensure that Fraud is properly monitored and reported.

5.3 Internal Audit

5.3.1 To review and approve the Internal Audit Annual Plan.

5.3.2 To review the adequacy of internal audit staffing and other resources.

5.3.3 To monitor audit progress and review audit reports.

5.3.4 To monitor the management action taken in response to the audit recommendations through an agreed follow-up mechanism.

5.3.5 To consider the Chief Internal Auditor's annual report and assurance statement.

5.3.6 To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.

5.3.7 To review the terms of reference and appointment of the Internal Auditors.

5.4 External Audit

5.4.1 To review the Audit Plan, including the Performance Audit Programme.

5.4.2 To consider all statutory audit material, in particular:

- Audit Reports (including Performance Audit Studies);
- Annual Reports;
- Management Letters.

5.4.3 To monitor management action taken in response to all External Audit recommendations including Performance Audit Studies (following consideration by the Staff Governance Committee or Clinical Governance Committee where appropriate).

5.4.4 To review the extent of co-operation between External and Internal Audit.

5.4.5 Annually appraise the performance of the External Auditors.

5.4.6 To note the appointment and remuneration of External Auditors and to examine any reason for the resignation or dismissal of the Auditors.

5.5 Standing Orders and Standing Financial Instructions

5.5.1 To review changes to the Standing Orders and Standing Financial Instructions.

5.5.2 To examine the circumstances associated with each occasion when Standing Orders are waived or suspended.

5.5.3 To review the Scheme of Delegation.

5.6 Annual Accounts

5.6.1 To review annually (and approve) the suitability of accounting policies and treatments.

5.6.2 To review schedule of losses and compensation payments.

5.6.3 Review the reasonableness of accounting estimates.

5.6.4 Review the external auditors management letter.

5.6.5 To review and recommend approval to the Board of the Annual Accounts.

5.6.6 To report in the Directors Report on the roles and responsibilities of the Audit Committee and actions taken to discharge those.

5.6.7 To review and recommend approval to the Board of the Patients Funds Annual Accounts.

6 AUTHORITY

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

7 PERFORMANCE OF THE COMMITTEE

The Committee shall review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis.

The committee shall provide guidelines and/ or pro forma concerning the format and content of the papers to be presented.

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

Subject to annual review
This revision: approved April 2019, reviewed March 2020

Paper No. 20/35

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2020
Agenda Reference:	Item: No 17
Sponsoring Director:	Finance & Performance Management Director
Author(s):	Finance & Performance Management Director / Board Secretary
Title of Report:	Annual Review of Standing Documentation
Purpose of Report:	For Decision

1 SITUATION

This report provides an update on proposed changes to Standing Documentation.

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 18 June 2020 and their recommendation was then noted for the Board's adoption.

3 ASSESSMENT

Aside from some minor typographical amendments, the undernoted changes are now reflected in the documentation.

3.1 Standing Financial Instructions

There are no amendments proposed to the Standing Financial Instructions, other than updates to reflect / correct up-to-date job titles.

3.2 Scheme of Delegation

Other than updates to reflect / correct up-to-date job titles, the only amendment is to section 14.8 d) where there is an addition at the lowest approval levels (< £5k, < £1k) for contract variances to allow the Programme Director and Deputy Programme Director to approve minor contractual variations due to the ongoing Perimeter Security Project. This was approved through the Project Board (chaired by the Chief Executive and with the Finance and Performance Management and Security Directors in attendance)

3.3 Standing Orders

Following the introduction of the Blueprint for Good Governance in February 2019, the Corporate Governance Steering Group was established through the NHS Board Chairs

Group, to review practices within NHS Boards. One of the areas identified for review was the production of a model Standing Orders for NHS Boards to reflect best practice.

Advice was issued by the Director General Health and Social Care and Chief Executive NHS Scotland, by way of DL (2019)24, to the effect that these model Standing Orders should be adopted by all health bodies in Scotland, save for Health Improvement Scotland and NHS National Services Scotland given that they are constituted under a different legal basis.

The Standing Orders for The State Hospitals Board for Scotland have been fully updated in line with this NHS national guidance and prescribed formatting, and were approved by the Audit Committee at its meeting on 26 March 2020.

4 RECOMMENDATION

The Board is asked to approve the 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?	Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No identified implications.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

STANDING FINANCIAL INSTRUCTIONS

VERSION 16

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 Board 18 June 2020

TABLE OF CONTENTS

TABLE OF CONTENTS *continued*

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 Performance Management 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 and Performance Management Director ("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.

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 Annual Operational 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

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.

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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).

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

- 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.

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.

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

- ✓ 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 rules on public procurement and comply with the 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:

- 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 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 £10,000 or greater (exclusive of VAT), competitive tenders 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 (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.

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 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 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 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).

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

	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

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.

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

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.

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.

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.

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.

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

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

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

SCHEME OF DELEGATION

VERSION 13

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. Issued to Audit Committee 26 March 2020 Issued to Board 18 June 2020

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 Performance Management 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 ("Annual Operational Plan") 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.
	7.1.9	FD	Procedures for financial management of capital investment.

	SFI Reference	Delegated to	Duties Delegated
	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.
	12.1.4	FD	Insurance arrangements.

	SFI Reference	Delegated to	Duties Delegated
	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 & Performance Mgt. 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	Finance Director	N/A	CG & RM standards Statement of Internal Control
5.2 Policies and Procedures				
Risk Management	Finance 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 (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 (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 (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 (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 (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 (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	Procurement Manager	Procurement Team Leader	< £10k	Subject to individual items authorised as above
m) Invoice matching queries	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	Procurement Manager	N/A	>£5k < £10k	refer to tendering procedures
b) Tenders Three minimum quotations for goods/services for spend over £10,000 and up to £100,000	Finance Director	N/A	>£10k < £100k	refer to tendering procedures
Three minimum quotations for goods/services for spend over £100,000	Chief Executive	N/A	>£100k	subject to EU regulations
c) Waiving of quotations & tenders subject to SOs	Chief Executive & Finance Director	N/A	N/A	
d) Arrangements for opening tenders	Procurement Manager	N/A	N/A	

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	

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 and the Scheme of Delegation

http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx

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

Date of Meeting:	18 June 2020
Agenda Reference:	Item No: 18
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

SITUATION

This paper summarises the current status of the Perimeter Security and Enhanced Internal Security Systems project.

BACKGROUND

The successful Contractor is Stanley Security Solutions Limited (Stanley). Key project information is:

Project Start Date:	April 2020
Planned Completion Date:	October 2021
Contract Completion Date:	January 2022
Main Contractor:	Stanley Security Solutions
Lead Advisor:	ThomsonGray
Programme Director:	Doug Irwin
Total Project Cost Projection (inc. VAT):	£10,346,263
Paid to date (Inc. VAT):	£2,058,506

Following the outbreak of Covid-19, and the subsequent decision to allow rephrased programming of the project to commence, a new programme was developed to work around the limitations that Covid-19 introduced. Further iterations of the programme have been developed and accepted as design work has progressed; these have not impacted on the Planned Completion Date of 15th October 2021.

The Governance for the project is provided by a Project Oversight Board chaired by the Chief Executive supported by the Director of Security, Estates and Facilities. The Board meets monthly, with an interim internal meeting taking place between full meetings. The meeting schedule and a review of the Terms of Reference were initially disrupted by the COVID19 outbreak, though this was short lived. The reviewed Terms of Reference are appended. An annual report to the Board was due in June however it is requested that this can be deferred to September 2020 in order to provide a more comprehensive report.

ASSESSMENT

1 FINANCE

A revised cost estimate is required due to changes that have taken place since the Commercial Evaluation against which the contract was awarded to Stanley. These changes include:

- Assessment of delay costs
- Assessment and inclusion of staff costs
- Revision of Contingencies
- Agreement on treatment of professional fees

The submitted FBC which recommended Pointer as the successful contractor contained a commercial evaluation relevant to that bid. Following the retender process, after which the Scottish Government confirmed that a new FBC was not required, the commercial evaluation accepted by TSH Board reflected the bids submitted during that exercise and confirmed the following final costs inclusive of VAT:

Pointer £8,326,542
Stanley £9,855,857

These estimated final costs included:

HVM Contingency to be awarded:	£180,000
Construction Contingency:	£180,000
Additional Contingency advised by Gateway Review	£200,000
Professional Fees	£625,320

The professional fees for Thomson Gray identified in the Commercial Evaluation were £470,000 plus a number of Compensation Events brought about by legal and tendering delays resulting in a projection of £625,320. Fees for a Construction Design Manager were not included. The original sum identified in the Thomson Gray contract was actually £485,338. Further additions due to mandated inflationary cost increases plus Compensation Events brought about by the extended legal and tendering processes and a revised estimate for Stage 4 resulted in an increase of £179,944 from the original activity schedule. As this should be accounted for against contingency sums it results in a double count and is removed from the calculations below.

It should be noted that the costs of the legal and tendering delays are approximately £230,000 including staff costs and additional professional fees. Central Legal Office costs are not included.

In addition to rectifying the double count, staff costs have now been added to the overall project cost and an additional contingency sum of £100,000 is included to offset the impact of delay costs.

Projected costs are now:

Item	Sum
Stanley anticipated final sum; includes £180k HVM Contingency (currently unallocated) £180k Construction Contingency	£7,533,215
Advisor fees (Exc. £10,182 CDM costs)	£485,338
Additional TSH Contingency (Original + £100k)	£300,000
Staff Costs	£364,000

Subtotal	**£8,682,553**
VAT (Exc. Staff Costs)	£1,663,710
Total Anticipated final sum including VAT	**£10,346,263**

Corrections to the professional fees of £25,520, the addition of £100,000 contingency, associated VAT of £25,000 and £364,000 staff costs result in an increase to the total anticipated final sum of £515,000.
Scottish Government are aware of the increased project costs and have requested monthly cash flow analysis reports. Specific confirmation has been sought on the inclusion of staff costs, and a formal response is awaited.

2 PROJECT WORKS

The project is proceeding according to plan and cost, quality and time targets are being met. A summary of planned and completed work is below:

On-site works

Works Completed:
Installation and testing of Fibre Network across site.

Works underway:

Installation of CCTV in Skye Centre	26th May – 20th July

Works Projected in coming two months:

Installation of CCTV in Arran Hub and Wards	21st July – 30th September
Tubestile replacement	29th June – 21st July
Moling under perimeter & add CCTV Columns	3rd July – 10th September
Arrival of 1st 2 batches of PAAs	25th June & 31st July

Programme dates are under constant review and are subject to change. A short life working group will be formed to oversee the ward decant process which is expected to be completed by May 2021.

Offsite works
Production and review of:

- Detailed design packages
- Risk Assessments and Method Statements

for all elements of the project.

Installation and configuration of equipment in the Factory Acceptance Testing facility at Swindon

RECOMMENDATION

That the Board **note** the current status of the Project and to **approve** the revised Terms of Reference and the request to defer the annual report to September 2020.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Maintain / improve safety and security
Workforce Implications	Admin support and Director costs to be addressed through revenue, though this is under discussion
Financial Implications	Overall reduction in maintenance cost if approved Significant increase in revenue requirement if not approved Capital expenditure if approved
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Project Oversight Board and Corporate Management Team
Risk Assessment (Outline any significant risks and associated mitigation)	Risk to service if not approved
Assessment of Impact on Stakeholder Experience	Addresses request from patients for introduction of CCTV in clinical areas
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

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:
Chief Executive Officer (Co-Chair)
Director of Security, Estates and Facilities (Co-Chair)
Finance and Performance Management Director
Director of Nursing and AHPs
Project Director
Employee Director
Scottish Prison Service

In Attendance:
Head of Estates and Facilities
Procurement Manager

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 provide a report to each NHS Board 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 September, 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.
12. To provide the necessary oversight and governance of the Change Control process.

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 sEPTEMBER 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:	February 2021

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	18 June 2020
Agenda Reference:	Item No. 19
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 May 2020
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 to 31 May 2020. Which is issued monthly to Scottish Government (SG) along with the statutory financial reporting template. And also reported to the Board, Senior Management Team and Partnership Forum.

2 BACKGROUND

Scottish Government are provided with an annual Operational Plan and 3-year financial forecast template, the draft version was sent but due to Covid-19 a final version has not been required yet. It set a balanced budget for 2020/21.
However the base budgets have now been set since and in line with the earlier balanced budget, this is set on achieving £1.321m efficiency savings, as referred to in the tables in section 4. £0.085m has been recognised over and above this in the base budgets.
The reason the savings are so much lower than last year is because additional income has been set as £0.500m for exceptional circumstance patients.

The annual budget of £37.852m is primarily the Scottish Government Revenue Resource Limit allocation, and anticipated RRL.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The Board is reporting an under spend of £0.085m to 31 May 2020.
Most of the covid-19 related spend to date has been met from the year end accrual. Details are being worked on and for future months a table will show the related spend. Nothing is recognised for the unidentified savings, of which the budget is phased to month12 (March '20). This will be assessed at the end of the first quarter.

Specific nursing controls were introduced in 2019 with the aim of reducing overtime – and that was evident from the significant reduction in overtime, and to provide meaningful comparisons for the future evaluation of the impact of the new clinical model in 2020/21. Covid-19 has now had an impact on this – please refer to further information below.

3.2 **Key financial pressures / potential benefits, that values have not yet been identified in the operational plan / base budgets.**

1920/21 PRESSURES	Risk	per annum (or per month) estimate £'k	Included in Reserves
Clinical Model Review	High	tbc	N
Office 365	High	250	N
Covid-19	High	250 pm	in part

Clinical Model review
The review of the clinical model has identified potential recurring savings in ward nursing, - values to be confirmed – which would be beneficial from early 2020/21 and will be monitored as part of the overall evaluation of the model. There are, however, potential unidentified 2019/20 costs yet to be determined subject to the steps required to prepare for the implementation of the model e.g. Estates costs. – Now principally deferred into 2020/21.

Office 365
NHS Scotland are directing all Boards to the implementation of Office365 in 2020. This will require input from all directorates and much staff commitment. While the plan was originally likely to be underway in early 2020, with timing now uncertain, the potential costs are being evaluated and should additional funding be required to meet the demands of this, a specific business case will be developed.

Covid-19
There were additional costs incurred in the final month of the financial year 2019/20 which are regarded as being specifically due to the Covid-19 crisis, together now with ongoing 2020/21 monthly recurring costs as the Hospital operates under new ways of working.

These costs for 2019/20 and 2020/21 have been formally reported to the Scottish Government's Covid-19 Health Finance team within the Health Finance and Infrastructure Directorate, and feedback / discussion has followed directly on these reports.

As previously notified, any specific costs in excess of £100k with relation to Covid19 are required to be notified for approval to Scottish Government - agreement being in line with new governance arrangements approved in April 2020 by Chief Executives and Directors of Finance.
During March, the undernoted revenue costs were specified in the Hospital's returns. Overtime costs March-May £495k, Delayed annual leave £44k, Covid-19 support team £35k per month, IT costs £20k, Equipment costs £8k, Estates/facilities costs £6k, Student nurse recruitment (NES funded) £260k.

For 2020/21, some of the above are ongoing, together with additional individually identified costs for deep cleaning, drugs, oxygen, and specific equipment, and costs to come regarding any staffing pressures of role requirements of new ways of working which are currently being evaluated.

It is understood that these costs both in late 2019/20 and now ongoing in 2020/21 should, in due course, be reimbursed from the Scottish Government's share of the funding being provided by the UK Treasury. However, while the position on this remains to be finalised the costs remain specific to the board, and will continue to be reported timeously in line with SG requirements.

Other

The Board are also asked to note that, during June, the recurring SLA with Lanarkshire for the provision of Social Work services was renewed at an annual cost of £530k – this was approved by the Chief Executive in line with the Scheme of Delegation as continuation of an existing annual professional services provision within the agreed budget.

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 2	Budget WTE	Actual WTE
Nursing And Ahp's	19,847	3,308	3,320	(12)	379.10	392.39
Security And Facilities	5,852	975	981	(5)	118.64	112.32
Medical	3,975	662	589	73	36.63	31.28
Chief Exec	1,848	308	303	5	22.27	22.87
Human Resources Directorate	836	139	119	20	13.45	12.08
Finance	3,047	508	483	25	38.39	35.66
Cap Charges	2,857	476	473	3	0.00	
Misc Income	(600)	(100)	(86)	(14)	0.00	0.00
Central Reserves	190	0	10	(10)	0.00	0.00
	37,852	**6,277**	**6,192**	**85**	**608.48**	**606.60**

Highlights:
Nursing & AHPs & Security & Facilities - see further detail below.

Medical - Vacancies in Psychology, coupled with staff on reduced hours.

Finance – Staff vacancies.

HR – Learning Centre – very little of the training budget utilised.

3.3.1 **Nursing & AHPs**

Nursing And Ahp's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 2	Budget WTE	Actual WTE
Advocacy	147	25	24	1	0.00	
AHPs & Dietetics & SLAs	687	114	114	0	13.33	13.92
Hub & Cluster Admin & Clinical Operations	803	134	132	2	23.17	19.99
NPD & Infection Control & Clin Gov	410	68	72	(3)	5.80	5.39
PCI & Pastoral	231	39	32	6	3.40	2.99
Skye Centre	1,680	280	268	12	38.33	35.30
Ward Nursing	15,889	2,648	2,677	(29)	295.07	314.80
	19,847	**3,308**	**3,320**	**(12)**	**379.10**	**392.39**

Highlights:-
Ward Nursing
Covid overtime pressure has been 'funded' from the accrual set March '20.
However further pressures in Nursing re high levels of sickness.

3.3.2 **Security and Facilities**

Security And Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 2	Budget WTE	Actual WTE
Facilities	4,221	703	697	7	78.87	73.99
Security	1,631	272	284	(12)	39.77	38.33
	5,852	**975**	**981**	**(5)**	**118.64**	**112.32**

Highlights:-
Facilities – Call charges have increased dramatically due to staff working from home. Full review of utilities budgets at the end of the first quarter.

Security – The overspend is due to changes in staffing structure, a pending workforce review should address this within the Directorate.

Perimeter Fence – Now being cross charged to capital as part of the FBC.

4 ASSESSMENT – SAVINGS

4.1 The following table is the savings set by Directorate, further discussions will be required to address the unidentified savings balance of £0.432m (of which none of this pressure is recognised in the year to date accounts). The vast majority of our savings are through vacancy management, which is treated as non-recurring.

Cumulative Savings	Savings - Annual Target	Achieved to date	(Still to be achieved) / over achieved	Memo - savings already in base
Directorate	**£'k**	**£'k**	**£'k**	**£'k**
Chief Executive	(143)	0	(143)	0
Finance	(49)	10	(39)	(30)
Nursing & AHP's	(315)	5	(310)	0
Human Resources	(15)	0	(15)	0
Medical	(144)	31	(113)	(55)
Security & Facilities	(235)	36	(199)	0
Unidentified	(421)	0	(421)	0
Total	**(1,322)**	**82**	**(1,240)**	**(85)**

While an improved level of the proportion of recurring savings is a national focus that has been highlighted by audit, it should be noted that of the Hospital's budget, nearly 85% of costs are pay/staff-related. The remaining non-pay cost element from which recurring savings are being pressured is therefore only 15%.
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%.

4.2 National Boards Contribution

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. With a challenging £15m collective savings target to be achieved per annum, there is pressure on each board to contribute towards any shortfall.

While the level to which the Board have agreed for 2019/20 has remained at £220k, there continued to be pressure due to the £15m not yet being fully attained.

5 CAPITAL RESOURCE LIMIT

The capital allocation anticipated from Scottish Government for the year is £0.269m.

Over and above this is the perimeter fence project allocation, this shows Year 1 of 2.

CAPITAL CRL	ANNUAL	YTD
AS AT MAY 2020	PLAN	SPEND
	£'k	£'k
PERIMETER SECURITY		
STANLEY SECURITY SOLUTIONS LTD		1,397
SECURITY CONTRACTING SERVICES LTD		101
THOMSON GRAY LTD		20
TSH STAFFING APR & MAY 20		24
PERIMETER SECURITY TOTAL	**9,150**	**1,543**
CAPITAL		
IM&T		15
OTHER		17
CAPITAL	**269**	**31**

6 RECOMMENDATION

Revenue
Year-to-date: £0.085m under spend.

Capital
Spend is on track and although spend is not in equal twelfths a break even outturn is anticipated. So in essence the planned funding will be aligned to actual spend so breakeven in month as well.

The Board is 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/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Head of Management Accounts
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. 20/38

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2020
Agenda Reference:	Item no: 20
Sponsoring Director:	Finance and Performance Management Director
Author:	Corporate Planning and Risk Project Support Officer Clinical Effectiveness Team Leader
Title of Report:	Performance Annual Report 2019/20
Purpose of Report:	For Noting

1 SITUATION

This report presents a high-level summary of organisational performance for the year from 1st April 2019 until 31st March 2020 and is based on the Local Delivery Plan (LDP) and its associated targets and measures. The data for Q1-Q4 are reported to present an overview of performance over the year (Appendix 1).

The only national LDP standards directly relevant to the State Hospital are as follows: Psychological Therapies Waiting Times and Sickness Absence. Additional local KPIs are reported to the Board and included in this report. A review of the broader LDP standards is also being undertaken at a national level.

The figures from the previous three years have been included for comparison. The comparisons between the years have been made on the same periods – annual data against annual data, rolling figures against rolling figures etc. (Appendix 2).

Quarterly trend graphs have been included (Appendix 3) to show trends over time since 2017.

It should be noted that due to the low number of patients, natural variations in the population can have an effect on the sample and small changes in our Key Performance Indicators (KPI) figures can look more significant when presented as percentages. These limitations should be borne in mind when considering this comparative data.

2 BACKGROUND

Members receive quarterly updates on Key Performance Indicator (KPI) performance as well as an Annual Overview of performance and a Year-on-Year comparison each June.

3 ASSESSMENT

No 1 Patient have their care and treatment plans reviewed at 6 monthly intervals.

Performance has decreased in 2019/20 as the figure ending March 2020 was 87.9% compared to a 96.1% from the previous year. This indicates that this performance has shifted from the green zone into red regarding Q4 results. Quarters 1,2 and 3 were all within the amber region and the annual average for this indicator was 91.7% and within the amber zone.

On 31 March 2020 there were 113 patients in the hospital. Fourteen of these patients were in the admission phase. Twelve CPA documents had not been reviewed within the 6-month period. All 12 were out of date (however all have been held and are not in RiO yet or were uploaded after 31/03/20). Reasons for the drop in compliance also include an RMO and their medical secretary being on sick leave which has had an impact on colleagues trying to cover, in addition to the ongoing situation regarding COVID-19.

Health Records staff continue to send reminder emails to RMOs and medical secretarial staff to advise that a patient's review or renewal of detention is due. The renewal of detention ties in with the annual CPA document being completed. These continue to be completed and uploaded to RiO by secretarial staff in shorter timescales than previously noted.

No 2 Patients will be engaged in psychological therapy.

Performance over the course of the year was above target for Q1, 3 and 4 – Q2 fell below the 85% target however remained in the green zone. Psychological Therapy Services have been actively engaging patients in the last quarter to ensure that all patients are encouraged to participate in psychological therapies.

No 3 Patients will be engaged in off-hub activities.

This indicator has seen a slight improvement from 81.7% in 2018/19 to 83% in 2019/20. There was slight fluctuation during the year that was mainly due to patient discharges and new admissions not being approved by the Clinical Team to attend activity at the Skye Centre within the agreed timeframe.

No 4 Annual Physical Health Review and No 10 Access to Primary Care.

The Health Centre consistently meets its targets with access to primary care being 100% for 2019/20 and annual physical health review averaging at 98.48%. There was a slight dip in Q4 as the GP was on sick leave and all annual health reviews were to be rescheduled – 14 patients in total were rescheduled from January and February and only 8 patients outstanding for an annual health review as of 31 March 2020.

The 48-hour access statistics are based on access to the appropriate healthcare professional, not solely the GP. Currently this would include the Practice Nurse, General Practitioners, Junior Doctors, Physiotherapist, Optician, Dental Team and NHS24.

No 5 Patients will undertake 90 minutes of exercise each week.

The target for this indicator is 80% and the overall average for year 19/20 was 60.7%.

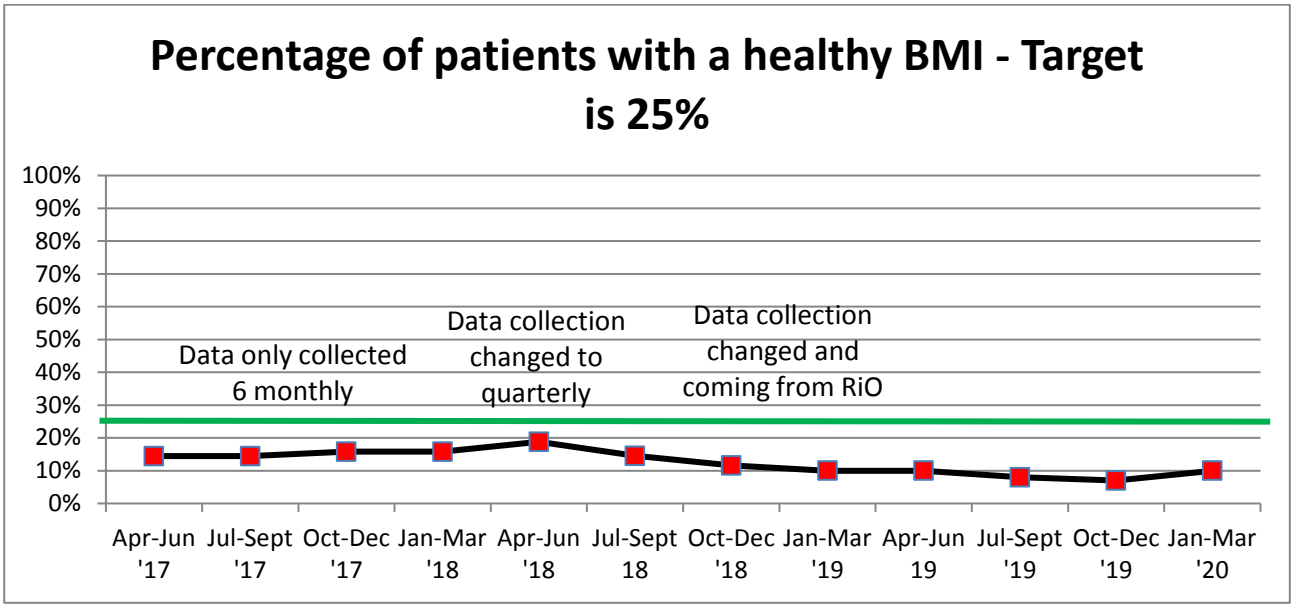
Q1 saw the activity levels average at 64.2% which was an increase from the end of year 18/19 Q4 data being 59.3%. Q2 increased again to 66.4% however, there was a steady reduction through Q3 and Q4 with their figures being 59.2% and 53% respectively. The contributing factor to this decrease is due to the Christmas period whereby the Sports, Fitness and the Gardens Departments were closed for several days due to the Public Holidays and the shortened ground access times allowing patients to utilise the grounds. As the forms are being completed on RiO, this continues to allow us to access physical activity data.

It is important to note there was an increase of patients participating in moderate physical activity through the month of November 2019 due to the number of TSH 30:30 projects which involved increasing patient's physical activity.

No 6 Healthier BMI.

The percentage of patients who have a healthier BMI decreased from 13.7% in the previous year to 8.75% in this 19/20 year. In Q4, however, there was the first sign of improvement in this indicator since April 2018. This indicator has remained in the red zone since its data collection period.

The data for BMI is now being input directly into RiO by nursing staff on the wards on a monthly basis rather than the dietetic assistant visiting wards on a 6 monthly basis to take these measurements. This allows for more frequent analysis on the BMI of our patients.



No 7 Sickness absence.

In the reporting period 1 April 2019 to 31 March 2020, the rate of absence was 5.92% compared to 8.26% in the previous year - this is a reduction to sickness levels by 2.34%. This is against a 5% target. This moves TSH into the amber zone from red for this year.

No 8 Staff have an approved PDR.

The PDR compliance level at 31 March 2020 was 87.1% - the year averaging at 86.68%. This is an increase from the 2019 figure of 80.9%%. As this indicator's target is 80%, this indicator is steadily within the green zone. Monthly monitoring is indicating a positive upwards trajectory and there is

clear evidence of month-on-month stability and an improvement in organisational compliance throughout Quarter 4.

No 9 Patients are transferred using CPA.

100% of patients were discharged / transferred using the Care Programme Approach (CPA) which is an increase on last year's performance of 97%.

No 10 – refer to No 4.

No 11 Patients will commence psychological therapies <18 weeks from referral date.

All but one patient commenced treatment within this timescale in the course of the year.

No 12 Patients will engage in meaningful activity on a daily basis.
No 13 Hubs have a monthly community meeting.

Indicators 12 and 13 are to be replaced. A Performance Management Task Force has been set up to review all the current KPIs and suggest more appropriate KPIs. Four logical models are being worked on at present as part of this piece of work.

No 14 Patients will have their clinical risk assessment reviewed annually.

Performance has remained only slightly below the 100% target throughout the year. The average figure for this indicator in year 19/20 is 97.68% and has steadily remained in the green zone in each quarter. Monitoring and auditing of the system integrated in 2017 are ongoing.

No 15 Attendance by clinical staff at case reviews.

The table below provides comparative data on the extent to which professions met their attendance target.

	Target	17/18	18/19	19/20	Increase/Decrease
RMO	90%	94.8%	90.9%	90%	-0.9%
Medical	100%	97.5%	97%	96%	-1%
KW/AW	80%	75.2%	63.6%	78.3%	+14.7%
Nursing	100%	96.5%	96.5%	97.8%	+1.3%
OT	80%	65.5%	64.2%	86.3%	+22.1%
Pharmacy	60%	57.2%	59.4%	61.3%	+1.9%
Clinical Psychologist	80%	70%	84.3%	71.3%	-13%
Psychology	80%	69.6%	84.5%	87.8%	+3.3%
Security	60%	59.8%	41.2%	52.5%	+11.3%
Social Work	80%	79.9%	80.8%	73.8%	-7%
Dietetics	tbc	3.0%	23.6%	60.8%	+37.2%
Skye Centre Activity	tbc	1.0%	1.1%	2.3%	1.2%
Hospital Wide	**n/a**	**64.2%**	**65.6%**	**71.5%**	**+5.9%**

RMO – during 2019/20, there was a minimal reduction in RMO attendance at case reviews. Whilst this reduced by 0.9%, the 90% target was still reached.

Medical – during 2019/20, there was 1% drop in medical attendance at case reviews. This reduction is still within the green zone for this indicator.

Key Worker/Associate Worker – there has been an increase of 14.7% in attendance for 2019/20. This means that they have risen into the green zone, despite just missing their target figure of 80%.

Occupational Therapy – during 2019/20, attendance from occupational therapy has risen by 22.1% from the previous year thus surpassing the 80% target by attaining an 86.3% attendance rate. This moves them from the red zone to green.

Clinical Psychologist – there has been a decrease of 13% attendance for 2019/20. This means that this clinical team have moved from green to the amber zone.

Security – performance has fluctuated throughout the year with the target of 60% not being met. There has been an 11.3% increase from 2018/19's figure of 41.2% in their attendance at annual and intermediate case reviews during 2019/20. This moves them from the red zone into amber for year on year analysis.

Social Work – there has been a 7% reduction in attendance at case reviews. This means that their target of 80% was not met and they move into amber territory from green in 2018/19.

Dietetics – during 2019/20, attendance from dietetics has risen significantly at case reviews by 37.2%. This can be attributed to the appointment of a dietician in 2019 as the post was vacant for some time. There is no target for this profession as of yet.

4 RECOMMENDATION

The Board is asked to **note the contents of this report.**

MONITORING FORM

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

APPENDIX 1

Key Performance Indicators

2018/19: Comparison across Q1-4

Item	Principles	Performance Indicator	Target	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan- Mar	LEAD
1	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	**92.6**	**91.7**	**94.7**	**87.9**	**LT**
2	8	Patients will be engaged in psychological treatment	85%	**92**	**90.7**	**81.9**	**87.1**	**JM**
3	8	Patients will be engaged in off-hub activity centres	90%	**83**	**84**	**80**	**85**	**MR**
4	8	Patients will be offered an annual physical health review	90%	**100**	**100**	**100**	**93.9**	**LT**
5	8	Patients will undertake 90 minutes of exercise each week	60%	**64.2**	**66.4**	**59.2**	**53**	**MR**
6	8	Patients will have a healthier BMI (bi-annual audit)	25%	**10**	**8**	**7**	**10**	**LT**
7	5	Sickness absence (National HEAT standard is 4%)	5%	**5.48**	**5.82**	**6.13**	**6.25**	**KS**
8	5	Staff have an approved PDR	80%	**86.3**	**86.9**	**86.4**	**87.1**	**KS**
9	1, 3	Patients transferred/discharged using CPA	100%	**100**	**100**	**100**	**100**	**LT**
10	1, 3	Patients requiring primary care services will have access within 48 hours	100%	**100**	**100**	**100**	**100**	**LT**
11	1, 3	Patients will commence psychological therapies <18 weeks from referral date	100%	**100**	**100**	**100**	**99.1**	**JM**
12	1, 3	Patients will engage in meaningful activity on a daily basis	-	**New indicators to be agreed.**				**MR**
13	2,6,7,9	Hubs have a monthly community meeting	-	**New indicators to be agreed.**				**MR**
14	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	**97.9**	**97.9**	**98.9**	**96**	**LT**
15		Refer to next table.						**All Clinical Leads**

Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q4	RAG Q3	Overall attendance Jan-Mar 2020 (n=42)	Overall attendance Oct-Dec 2019 (n=51)	Overall attendance July-Sept 2019 (n=44)	Overall attendance April – June 2019 (n=50)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	G	90%	86%	91%	93%
				Medical **(LT)**	100%	G	G	95%	98%	95%	96%
				Key Worker/Assoc Worker **(MR)**	80%	G	G	78%	82%	81%	72%
				Nursing **(MR)**	100%	G	G	95%	98%	98%	100%
				OT**(MR)**	80%	G	G	90%	93%	79%	83%
				Pharmacy **(LT)**	60%	G	G	68%	57%	63%	57%
				Clinical Psychologist **(JM)**	80%	R	G	67%	80%	61%	77%
				Psychology **(JM)**	100%	A	R	90%	84%	86%	91%
				Security**(DW)**	60%	R	G	44%	68%	56%	42%
				Social Work**(KB)**	80%	A	G	74%	75%	72%	74%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc	-	-	0%	4%	5%	0%
				Dietetics **(MR)** (only attend annual reviews)	tbc	-	-	64%	67%	45%	67%

APPENDIX 2: KEY PERFORMANCE INDICATORS 2018-19 AND COMPARISION WITH 2018-19, 2017-18 AND 2016-17

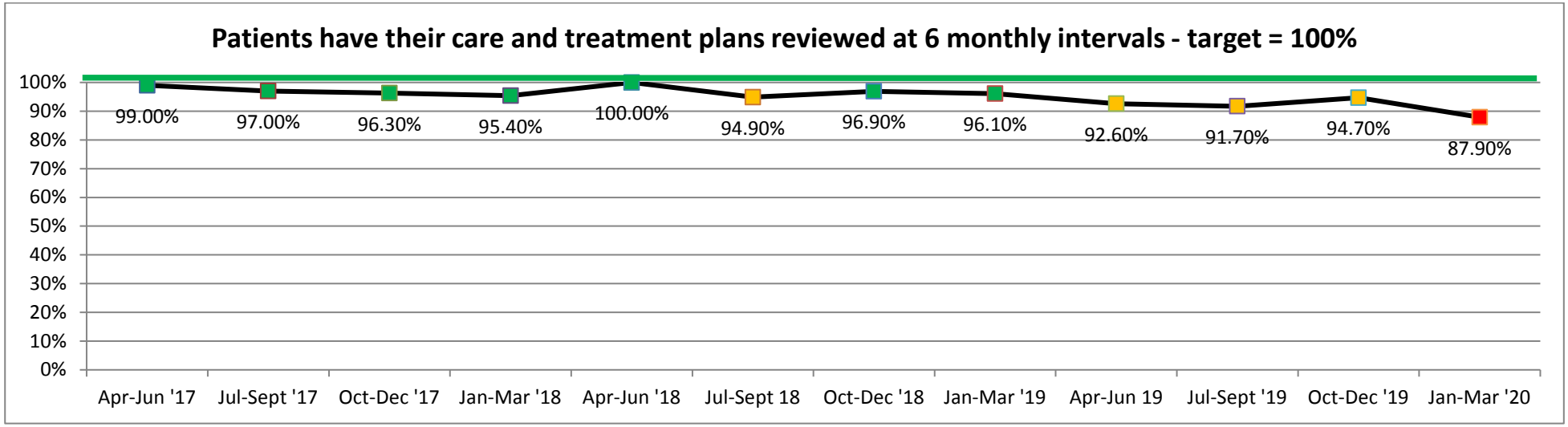
Item	Principles	Performance Indicator	Target	RAG	19/20	18/19	17/18	16/17		LEAD
1	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	**A**	91.73%	96.9%	95.4%	91%	*Figure to March each year.*	**LT**
2	8	Patients will be engaged in psychological treatment	85%	**G**	87.93%	92.8%	94.4%	96.4%	*Figure to March each year.*	**MS/ GM**
3	8	Patients will be engaged in off-hub activity centres	90%	**A**	83%	81.7%	78.7%	79.3%	*Attendance averaged for the year.*	**MR**
4	8	Patients will be offered an annual physical health review.	90%	**G**	98.48%	93%	100%	100%	*Figure for Apr 2019 - Mar 2020.*	**LT**
5	8	Patients will undertake 90 minutes of exercise each week (Annual Audit)	80%	**R**	60.70%	56.3%	Q4 only 48.7%	-	*Average figure for April 2019 – March 2020.*	**MR**
6	8	Patients will have a healthier BMI	25%	**R**	8.75%	13.7%	15.8%	13.6%	*Average figure from April 2019 – March 2020.*	**LT**
7	5	Sickness absence (National HEAT standard is 4%)	** 5%	**A**	5.92%	8.26	8.52%	8.35%	*Figure for April 2019-March 2020.*	**JW**
8	5	Staff have an approved PDR	*80%	**G**	86.68%	80.9%	84.7%	73%	*Figure to March 2020.*	**JW**
9	1, 3	Patients transferred/discharged using CPA	100%	**G**	100%	97%	99%	100%	*Figures for April 2019 - March 2020.*	**KB**
10	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	**G**	100%	100%	100%	100%	*Figures for April 2019 - March 2020.*	**LT**
11	1, 3	Patients will commence psychological therapies <18 weeks from referral date	**100%	**G**	99.78%	98.5%	100%	100%	*Figure to March 2020.*	**MS/ GM**
12	1, 3	Patients will engage in meaningful activity on a daily basis	100%	**-**			-	-	*New indicators to be agreed.*	**MR**
13		Hubs have a monthly community meeting	100%	**-**			-	-	*New indicators to be agreed.*	**MR**
14	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	**G**	97.68%	99%	99.1%	97%	*Figure to March 2020.*	**LT**
15	2, 6, 7, 9	Attendance by all clinical staff at case reviews	See above	**-**	71.5% overall	65.6% overall	64.2% overall	59% overall	*Figures for April 2019- Mar 2020.*	**All Leads**

Definitions for red, amber and green zone

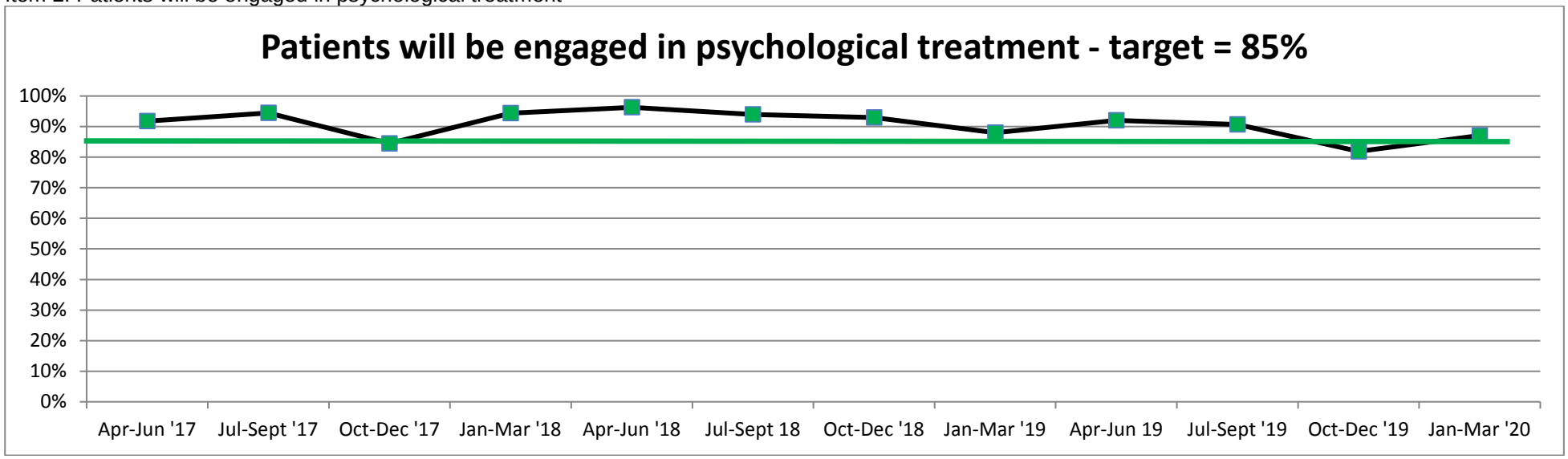
- For all but item 6 and 7: green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target
- For item 6 ‘Patients have a healthier BMI’: green will be 3% or less away from target, amber will be between 3.1% and 5% away from target and red will be over 5% away from target
- For 7 ‘Sickness absence’: green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over 1% and away from target

Appendix 3: Trend Graphs for Performance Management Data

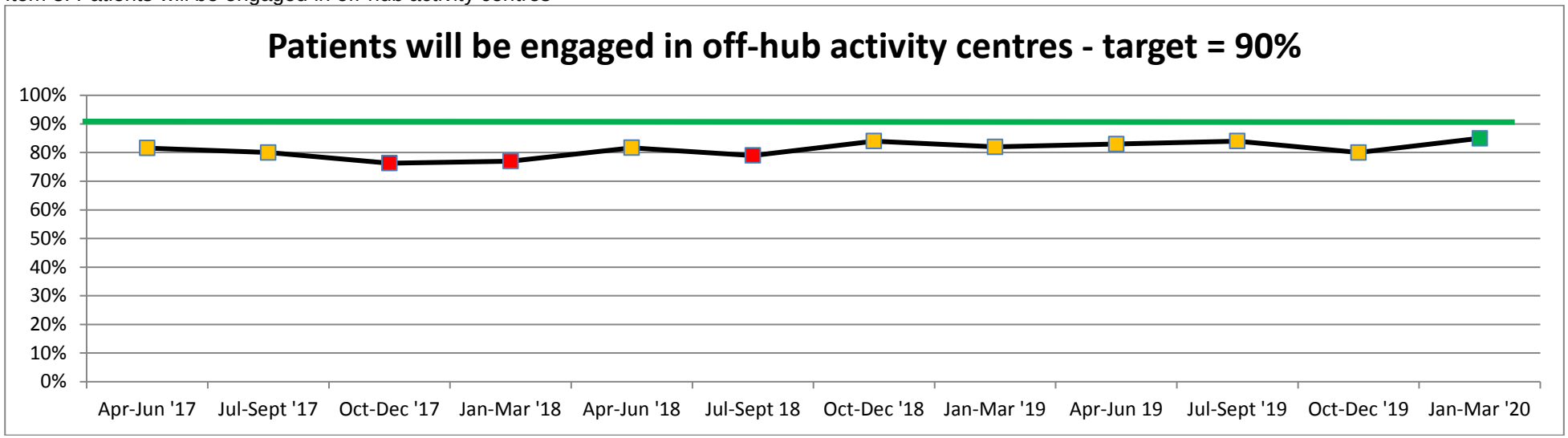
Item 1: Patients have their care and treatment plans reviewed at 6 monthly intervals



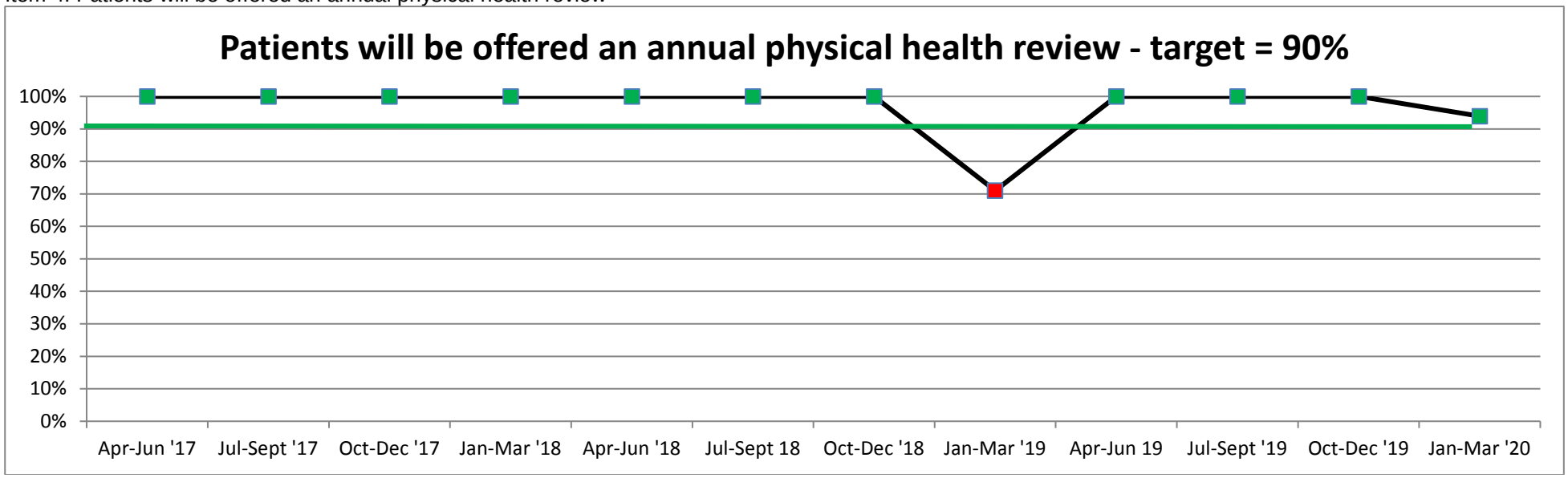
Item 2: Patients will be engaged in psychological treatment



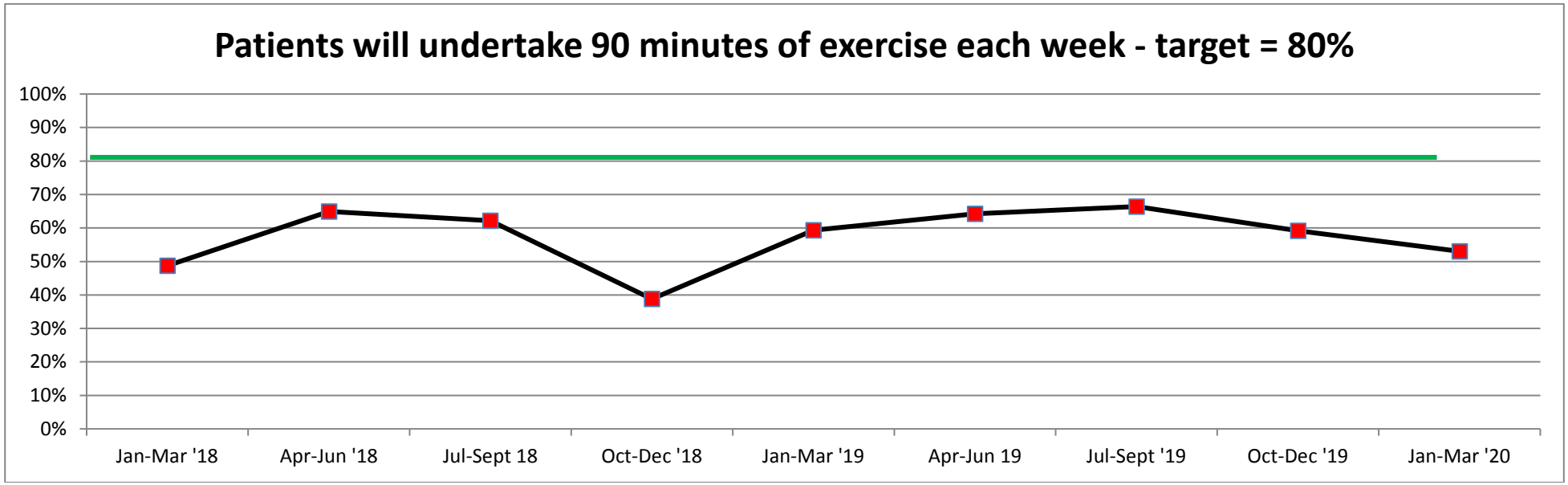
Item 3: Patients will be engaged in off-hub activity centres



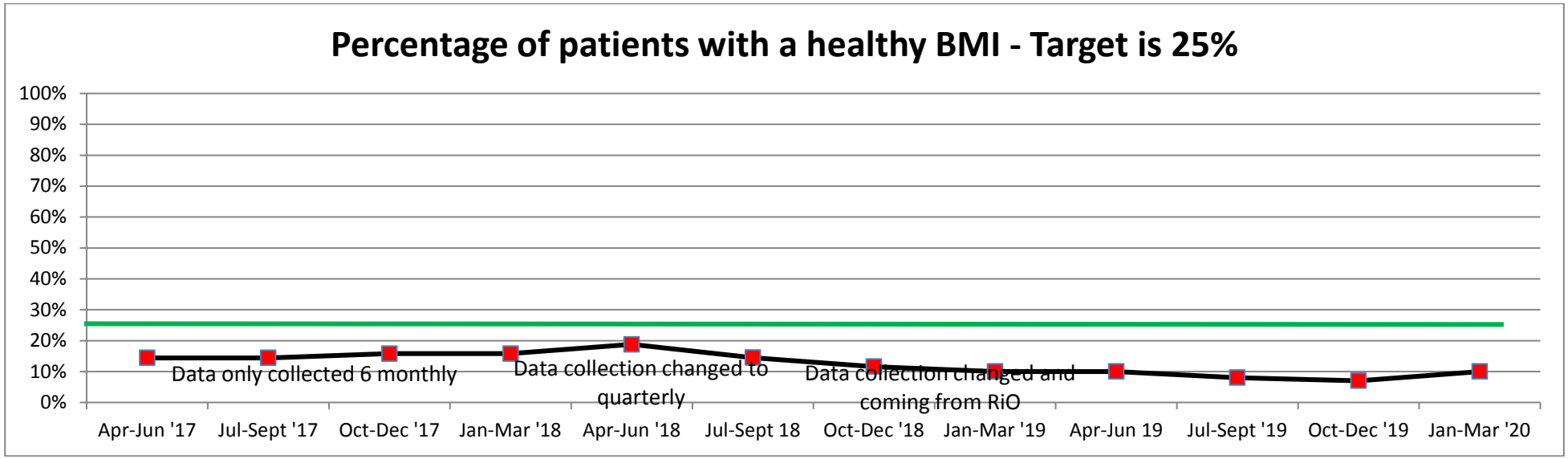
Item 4: Patients will be offered an annual physical health review



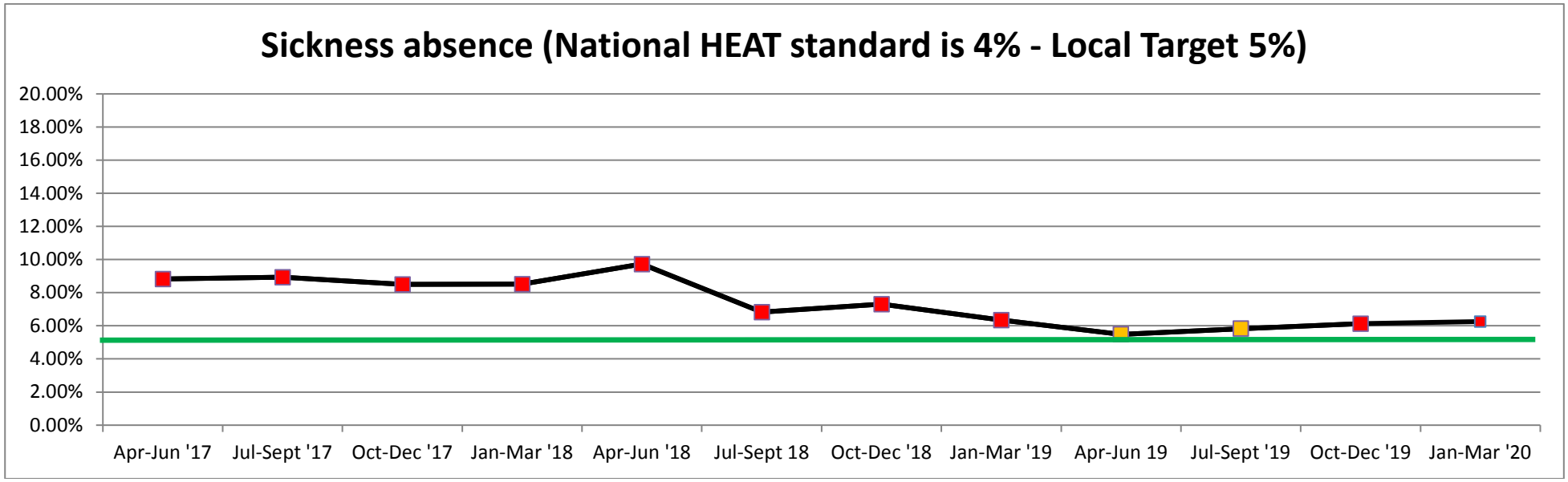
Item 5: Patients will undertake 90 minutes of exercise each week



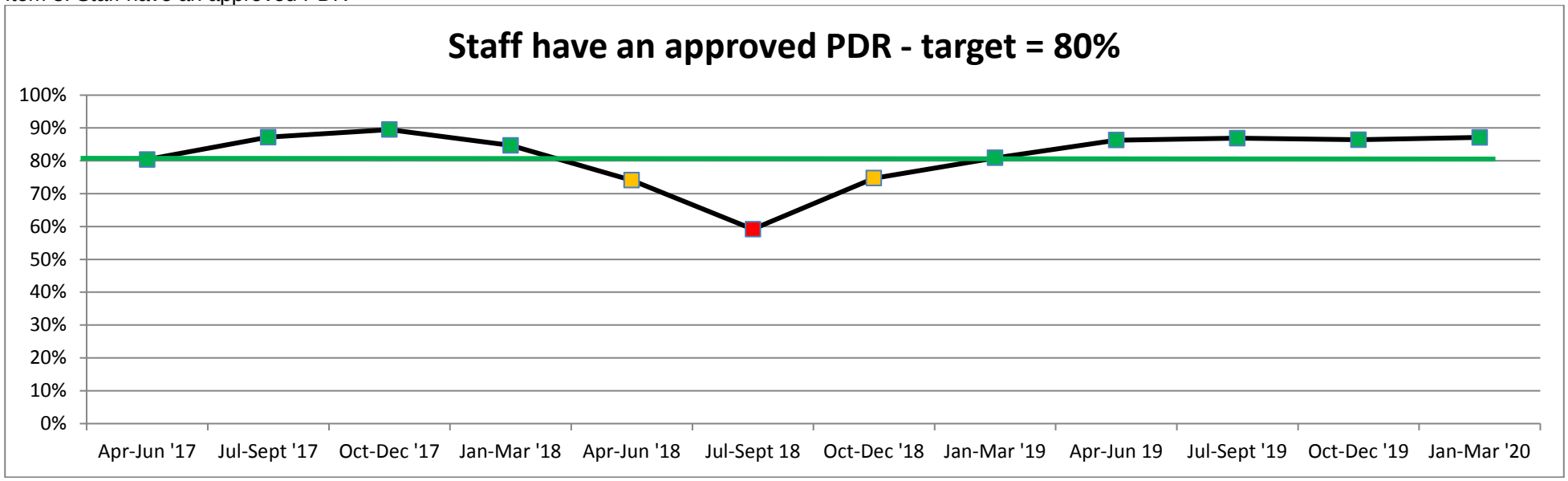
Item 6: Patients will have a healthier BMI



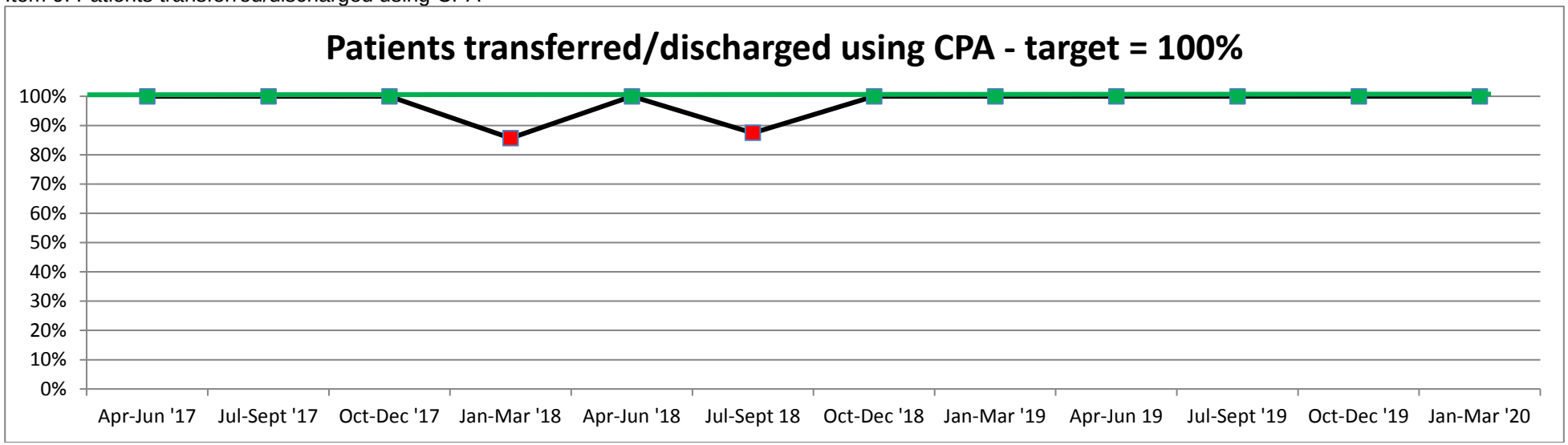
Item 7: Sickness Absence



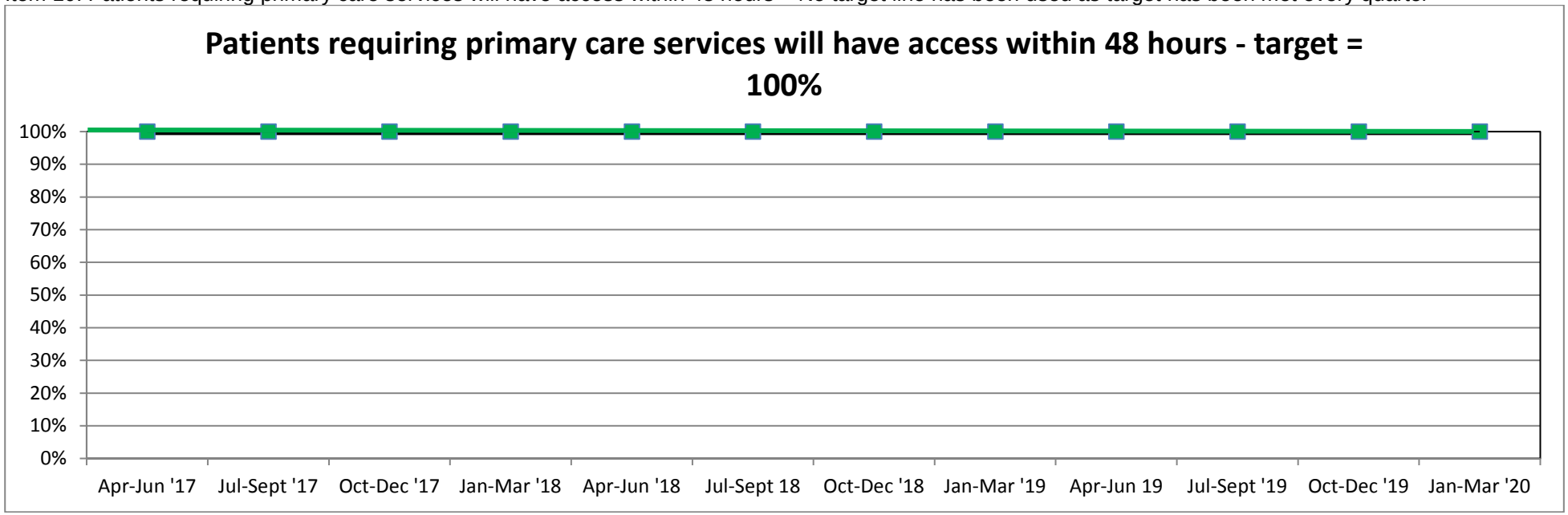
Item 8: Staff have an approved PDR



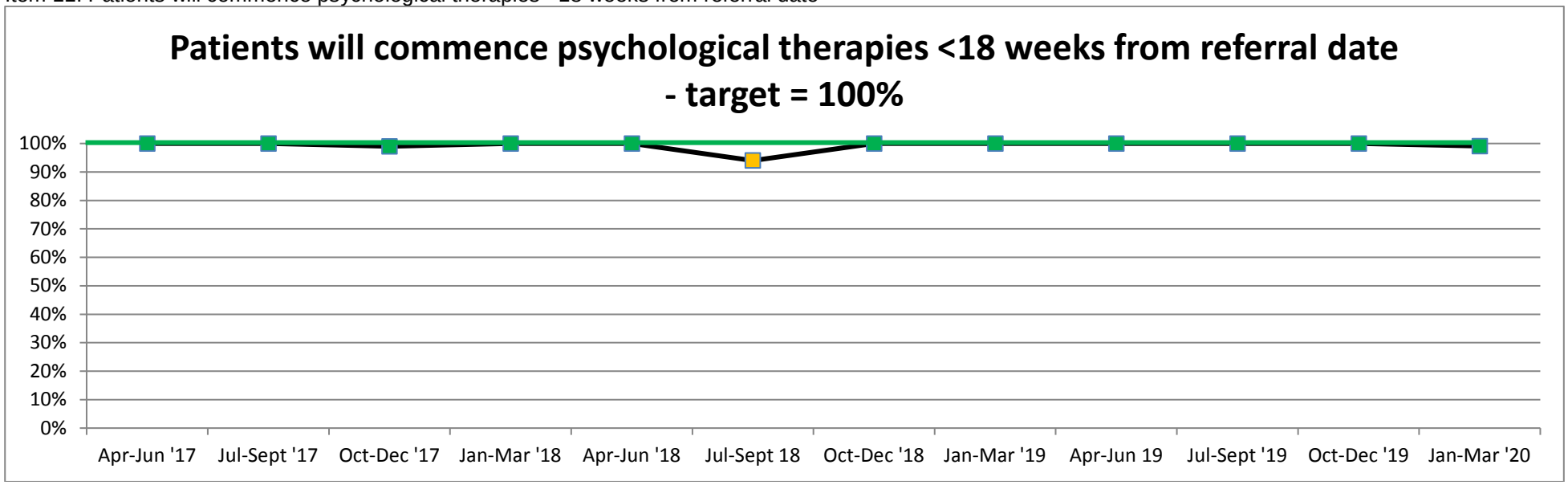
Item 9: Patients transferred/discharged using CPA



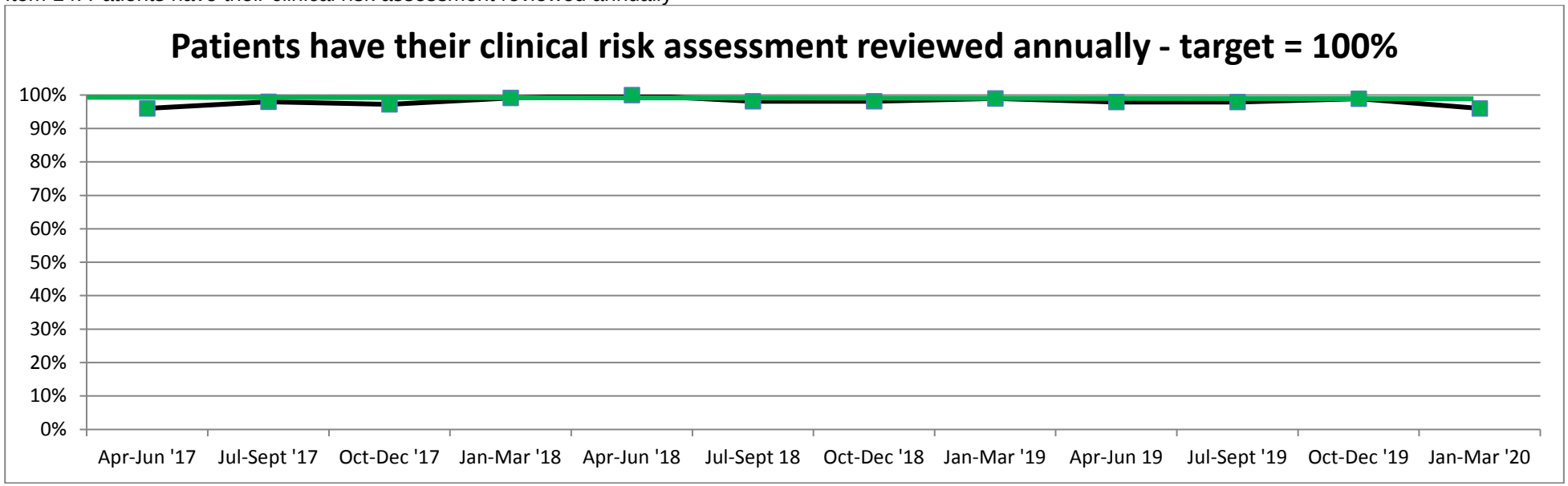
Item 10: Patients requiring primary care services will have access within 48 hours – No target line has been used as target has been met every quarter



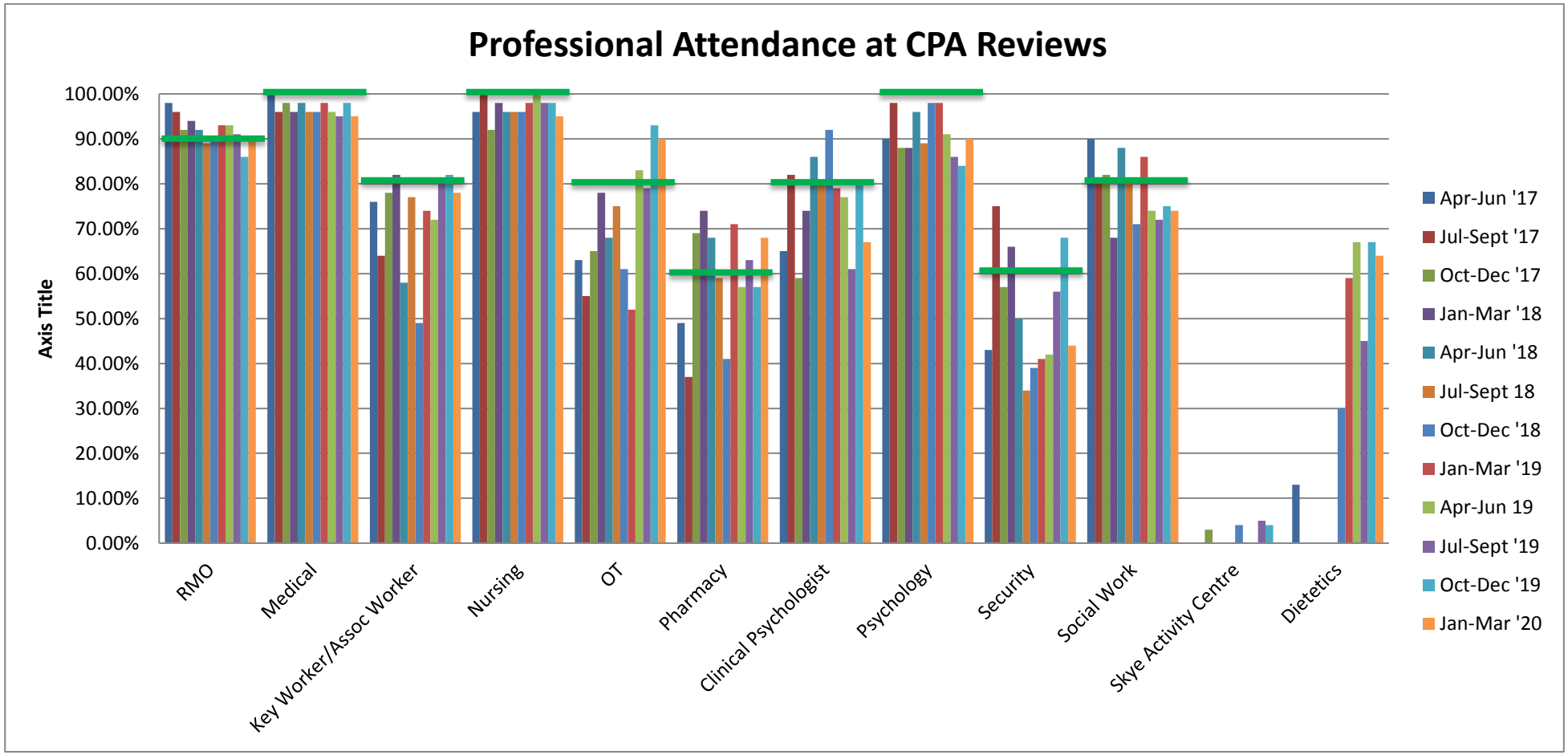
Item 11: Patients will commence psychological therapies <18 weeks from referral date



Item 14: Patients have their clinical risk assessment reviewed annually



Item 15: MDT Attendance at Case Review



Paper No. 20/39

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2020
Agenda Reference:	Item No: 21
Sponsoring Director:	Director of Security, Estates and Facilities
Author(s):	Head of Estates & Facilities
Title of Report:	Property and Asset Management Strategy Update Report
Purpose of Report:	To inform the Board of the Property and Asset Management Strategy for 2020

1 SITUATION

The Scottish Government Health Finance, Corporate Governance and Value Directorate has emailed Boards notifying them of the arrangements for the State of NHSScotland's Infrastructure (SAFR) programme and Property and Asset Management Strategy (PAMS) for 2020. No formal letter will be issued by Scottish Government about this year's programme.

For this year, there has been no deadline set for the return of the SAFR pro forma templates. In terms of PAMS the indication is that they will only be asking for a brief update by the end of December. These decisions have been taking due to the Covid-19 pandemic and increased pressures within Health Boards.

2 BACKGROUND

The 2017 – 2022 PAMS was approved by the Board in June 2017 prior to submission to Scottish Government Health and Social Care Directorate.

3 ASSESSMENT

The SAFR pro forma templates will be completed and returned for the end of June 2020. Requirement for PAMS will be updated to the Board once further information is received from Scottish Government.

4 RECOMMENDATION

That the Board **notes** the content of this paper.

Paper No. 20/39
MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Support of PAMS policy for the Board
Workforce Implications	As detailed, no specific
Financial Implications	As per report
Route To Board Which groups were involved in contributing to the paper and recommendations.	To comply with Scottish Government request / Board Workplan
Risk Assessment (Outline any significant risks and associated mitigation)	As per report
Assessment of Impact on Stakeholder Experience	As per report – none identified
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Audit Committee held on Thursday 26 March 2020 at 9.45am which took place via teleconference A(M)20/02

PRESENT:

Non Executive Director	Bill Brackenridge
Employee Director	Tom Hair
Non Executive Director	David McConnell ***(Chair)***
Non Executive Director	Brian Moore

IN ATTENDANCE:

Internal

Board Chair	Terry Currie
PA to Finance and Performance Management Director	Fiona Higgins ***(Minutes)***
Chief Executive	Gary Jenkins *(items 1 – 4 and 19)*
Finance and Performance Management Director	Robin McNaught
Board Secretary	Margaret Smith

External

Senior Manager, RSM UK	Asam Hussain
Director, Scott Moncrieff	Karen Jones
Head of Internal Audit, RSMUK	Marc Mazzucco

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

David McConnell chaired the meeting and welcomed those joining the meeting, which was undertaken via telephone conference in order to comply with Covid19 social distancing restrictions.

There were no apologies for absence noted.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted.

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 23 January 2020 were amended at page 6, item 14 Policy Update to reflect that the report provided an update to January 2020, and were subsequently approved as an accurate record.

ACTION: FIONA HIGGINS

4 MATTERS ARISING AND ACTION NOTES UPDATE

Members noted that all actions were either complete, on the agenda or delayed due to Covid19 restrictions or priority.

COVID 19 BRIEFING

Members received a verbal briefing from Gary Jenkins, Chief Executive, on the operational and corporate approach being taken by the Hospital in relation to Covid 19.

The Hospital commenced operation of its gold/silver/bronze resilience structure on week commencing 9 March 2020, this allows the Hospital to operate under an incident command structure and is managed and monitored on a daily basis with Gold meetings led by the Chief Executive on a weekly basis, Silver meetings are led by the Nursing and AHP Director and the Security Director on a daily basis with Bronze leads feeding into the Silver command structure on a daily/ongoing basis.

Members were advised that as well as the internal controls afforded through the incident command structure there are daily and weekly teleconference meetings with the Scottish Government across all relevant directorates with all Directors at the State Hospital feeding into their relevant departments within the Scottish Government to ensure updates are both received and reported. The Hospital is also aligned with the Lanarkshire Resilience Partnership; the three English Special Hospitals and the medium secure units across Scotland.

At present a number of measures have been put in place across the site to ensure compliance with Health Protection Scotland Guidance and restrictions/advice received from the Scottish Government. These measures are subject to change in order to maintain compliance and ensure patient and staff safety.

Members noted that it is anticipated that a move to a more restrictive practice will be required following expected instructions from the Scottish Government at this morning's briefing.

Members acknowledged the benefit of the daily updates provided by the Covid Support Team and noted their appreciation to staff and management for their actions and commitment in these exceptional circumstances.

Gary Jenkins left the meeting

INTERNAL CONTROL AND CORPORATE GOVERNANCE

5 ATTENDANCE MANAGEMENT UPDATE

A report was submitted by the Interim Director of Human Resources which provided Members with an update on attendance across the organisation based on the data available from January 2019. The current monthly figure for December 2019 shows no significant change at 6.41% which provides a current rolling 12 month average as 5.89%.

Members noted that recorded Covid19 related absences in relation to self isolating and symptomatic are being categorised under a separate Special Leave category and are reported daily via the Silver Bulletin to all staff. This reporting mechanism will allow a clear picture of Covid related absences throughout the pandemic.

Members noted the content of the report, acknowledging the context of the current Covid 19 developments.

6 FRAUD UPDATE

A report was submitted by the Finance and Performance Management Director to provide an update on fraud allegations and notifications received from Counter Fraud Services. Four alerts had been received, however none of these were specific to the State Hospital. Following the issuing of the report members noted that an alert in relation to a Covid19 scam had since been published.

The Committee were content to note the detail of the report.

7 FRAUD ACTION PLAN

The Committee received and noted the paper which provided an update on Board engagement with Counter Fraud Services (CFS). Robin McNaught advised that the annual review with CFS, initially scheduled to take place in April 2020, would now be rearranged on conclusion of Covid 19 restrictions. A minor amendment was noted to Appendix 1 (Fraud Action Plan) to change the date to May 2019.

Monica Merson highlighted the increase of "phishing" scams through NHS mail and Robin McNaught advised that there are robust checks in place, particularly in relation to the Hospital purchasing application (Pecos) and that staff are reminded regularly to be alert to potential scam emails.

The Committee noted the progress on engagement activities; noted the update on Communication; reviewed the Fraud Action Plan (Appendix 1) and noted the review of the Top Ten Risks identified from the FRAM (Appendix 2) a review of which is scheduled within the next financial year.

8 CORPORATE RISK REGISTER UPDATE

The Committee received a paper from the Finance and Performance Management Director which provided an update on the current risk registers. This included the addition of two new risks, Water Management (contamination of water supply) which had been approved for inclusion at the Risk, Finance and Performance Management Group on 5 March 2020 and a specific risk for the impact that Coronavirus (Covid19) may have on the Hospital's primary aim to provide high quality, effective care and treatment and to maintain a safe and secure environment for patients and staff.

Members noted the addition of the two new risks, noted the report and the impact that the Covid19 risk may have on other risks,

9 RISK STRATEGY

The Committee received a copy of the Risk Register Guidance / Risk Management Strategy from the Finance and Performance Management Director. The strategy has been updated following the recommendations of an internal audit undertaken in March 2019. This was approved through the Risk, Finance and Performance Management Group and is presented to members for noting.

Members asked that the minutes of the Risk, Finance and Performance Management Group be added as a standing item to the Audit Committee agenda.

ACTION: FIONA HIGGINS

Members noted the Risk Register Guidance / Risk Management Strategy.

10 CATEGORY 1 AND 2 UPDATE ON OUTSTANDING ACTIONS

The Committee received an update report on all outstanding actions arising from Category 1 and Category 2 adverse event reviews, and noted that the Chief Executive takes the lead in reviewing progress with the Corporate Management Team on a monthly basis and that the Risk, Finance and Performance Group also review the outstanding items on a quarterly basis.

Members noted that there had been improvement since the previous report with only 4 actions remaining outstanding and that these are being progressed as a priority. However in light of Covid19 these may incur an unexpected delay with completion.

Terry Currie commented on the new format and advised that this was helpful, however he asked that future reports include a narrative providing the reasons for delay in completing the actions.

ACTION: NICOLA WATT

11 POLICY UPDATE

The Committee received a report on Policies which was prepared by the Clinical Effectiveness Team Leader and presented by the Finance and Performance Management Director. The report advised that at March 2020 from 134 policies, 23 are currently out of date, a slight improvement from the previous report, however this was short of the target of 18 policies set at the previous meeting.

Members noted the improvement and acknowledged the more proactive approach being taken by policy owners in relation to addressing policy reviews in advance of them approaching the review date and welcomed this progress.

Members noted that there may be a slippage with progress in light of Covid19 and the short term requirement to focus on the delivery of service, however were encouraged that a robust process is now in place in order to provide assurance to the Committee that policies remain a key priority.

The Committee noted the improvements in policies since the previous report.

INTERNAL AUDIT

12 AUDIT PROGRESS REPORT 2019/20

The Committee received a report from RSMUK which outlined the progress made against the internal audit plan for 2019/20. Marc Mazzucco summarised the report noting that fieldwork in relation to the Clinical Observations Audit was now complete and no concern raised, the report is expected to be available to the June Audit Committee. Work continues remotely in relation the annual accounts review however it has been necessary to delay the Patient Property Audit due to Covid19 restrictions preventing auditors from being able to undertaken the necessary fieldwork. Mr Mazzucco also confirmed the move of the audit on the Clinical Model to 2020/21 audit period and advised that it is expected that a positive conclusion to the audit will be achieved for 2019/20.

The Committee noted the Audit Progress Report

13 MANAGEMENT ACTION TRACKING REPORT

The Committee received and noted the tracking report from RSMUK in relation to management actions taken forward in response to internal audit recommendations. Asam Hussain advised that from the action tracker, one action had been implemented, one is in progress and 17 have yet to reach their due date.

The Committee noted that a high number of actions were flagged for completion at the end of March/April and acknowledged that due to the Covid19 restrictions and priorities an extension to these dates may be necessary. Monica Merson agreed to review the actions with due dates in March and April and speak with the action owner to agree any required amendment to the due date.

ACTION: MONICA MERSON

Tom Hair welcomed the option to do this, highlighting that staff across the site are extremely busy implementing changes to operational practices as a result of Covid19 with some clinical staff having to return to more clinical based roles. It was agreed that Tom Hair and Robin McNaught look at reallocating the actions for those staff who may have to undertake a different role during the Covid19 pandemic.

ACTION: TOM HAIR/ROBIN McNAUGHT

The Committee noted the content of the report.

14 DRAFT INTERNAL AUDIT PLAN 2020/21

RSMUK submitted the internal audit plan for 2020/21 for The State Hospital based on the organisation's corporate objectives, risk profile and Corporate Risk Register as well as other factors affecting the organisation in the year ahead, including the implementation of a new Clinical Model. Asam Hussain advised that he had met with all Executive Directors in early March to agree the content. He also highlighted the inclusion in the report of additional areas, not in the plan, but which may be eligible for second line assurance.

David McConnell acknowledged that some areas of the plan may potentially be impacted due to the Coid19 situation and RSMUK confirmed that they would remain flexible and refine the Audit Plan as required.

Monica Merson advised that the Hospital is moving to a remote/home working practice where possible and asked if there were any operational resilience areas that perhaps audit would be interested in reviewing.

Tom Hair commented that the Hospital has never operated a Working from Home Policy and that staff have not previously had the ability/option to do so and agreed that it would be helpful to have a review of this, to ensure there is a secure and robust process in place for any future home working.

Robin McNaught advised that a review, perhaps in 6 weeks time, would be useful in order to identify the weaknesses; understand any mitigations; and review the use of remote access tokens and remote access to sensitive materials. At present the eHealth department are developing appropriate structures in order that home working across all departments can be facilitated securely and effectively where appropriate for home working to be undertaken.

The Committee noted and agreed the draft Audit Plan for 2020/21 with a caveat that an advisory audit/ review of remote access/home working could be undertaken.

ACTION: RSMUK/ROBIN McNAUGHT/MONICA MERSON

EXTERNAL AUDIT

15 INTERIM AUDIT REPORT

Members received a verbal update from Scott Moncrieff in their role as external auditor. Karen Jones advised the Committee that, following the February Planning Visits and work undertaken on annual accounts, which inform the 2019/20 audit process, the external auditors were able to confirm that no issues were found around the key financial systems and as such there is no requirement for a formal report to be provided to this meeting. A formal year end report will be presented at the June meeting.

The committee noted the verbal report from the external auditor.

STANDING DOCUMENTATION

16 REVIEW OF STANDING DOCUMENTATION

The Committee received a report from the Finance and Performance Management Director to advise that there were no proposed changes to the Standing Financial Instructions and Scheme of Delegation. The Hospital Standing Orders have been updated to be in line with NHS national guidance and prescribed formatting following the introduction of the Blueprint for Good Governance in February 2019 where a review of standing orders for NHS Boards was undertaken and amendments made to reflect best practice and reflect the DL (2019)24, as issued.

The Committee provided approval for this documentation to be submitted to the next meeting of the Board.

17 REVIEW TERMS OF REFERENCE AND CODE OF CONDUCT

The Committee approved the terms of reference and code of conduct as presented by the Finance and Performance Management Director.

18 REVIEW OF ACCOUNTING POLICIES

A report was received from the Finance and Performance Management Director to provide Committee with an update on the current position with regard to any changes to Accounting Policies based upon Financial Reporting Manual guidance.

It was noted that currently there are no changes to the accounting policies however 1.1 (a) and (b) maybe be updated by National Services Scotland who are supporting the Hospital in the preparation of the year end accounts.

The Committee approved the changes; asked that future reports have a covering report highlighting the changes and noted the caveat of possible changes to section 1.1 (a) and (b).

ACTION ROBIN McNAUGHT

OTHER ISSUES

19 ANY OTHER BUSINESS

Annual Accounts

David McConnell raised the issue of whether the present Covid 19 disruption could impact on the administration of the Board's various responsibilities for year end financial and related reporting. Robin McNaught advised that in light of Covid19 there may be challenges in relation to the conclusion of year end accounts. This is currently being taken forward via the Corporate Finance Network and Audit Scotland with possible options being discussed including:

- continuation with the normal process and timelines;
- abbreviated/light year end review
- 3 to 6 month extension
- a year end date change, for example to 30 June 2020

Karen Jones concurred that this was the information they had received as external auditors and advised that they would comply with the guidance issued and be flexible and work remotely in order to ensure completion of the accounts and audit.

The committee noted the position and that members would be informed as matters developed.

Corporate Governance Arrangements during Public Health Emergency – Covid19

Terry Currie advised that he had received a letter from the Scottish Government Health Finance, Corporate Governance and Value Directorate requiring Boards to provide assurance that effective governance is maintained, though this may be different from the structure currently in place, and that any proposed change should, for good governance reasons, be presented to the Board as quickly as possible. The Scottish Government have advised that any change to governance should:

- enable agile and effective decision making
- place staff and their resilience at the centre
- build important links with the public and community at this time
- ensure that Boards operate in an open and transparent to enable public scrutiny

Any review should be conducted within the requirements of existing legislation and in reference to the existing standing orders of the Board.

Margaret Smith advised that she is seeking guidance from the other NHS Board Secretaries to ensure continuity across all Boards.

Terry Currie advised members that the current command structure allows the Gold Commander, Gary Jenkins, wide ranging authority to necessitate speed of decision making, and at this time it may be a requirement for short notice teleconference style Board meetings.

Members agreed that directly following the Audit Committee meeting Terry Currie; Gary Jenkins; Margaret Smith; Robin McNaught and David McConnell meet to prepare a report for the Board and a response to the Scottish Government on any proposed changes to governance arrangements.

ACTION: TERRY CURRIE/GARY JENKINS/MARGARET SMITH/ ROBIN MCNAUGHT/DAVID MCCONNELL

20 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Thursday 18 June 2020. The location and related arrangements are to be confirmed.

The meeting ended at 12 noon

Paper No. 20/40

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2020
Agenda Reference:	Item No: 23
Sponsoring Director:	Finance & Performance Director
Author(s):	Risk Management Team Leader
Title of Report:	Corporate Risk Register – Very High/High/Medium risks
Purpose of Report:	For Discussion

1 SITUATION

This paper is prepared to provide oversight to the Board of the medium, high and very high risks featuring on the Corporate Risk Register and to provide assurance that these are being addressed.

2 BACKGROUND

This report provides an update on Very High, High and Medium Corporate Risks that are currently recorded on the Corporate Risk Register. The Corporate Risk Register was presented to the Audit Committee in March and is also a standing agenda item on the quarterly Risk, Finance and Performance Committee.

3 ASSESSMENT

Current Corporate Risk Register is detailed within Appendix A.

There is one Very High risk:

CE 14 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.

The 6 following risks are graded as High:

MD30 Failure to prevent/mitigate obesity
*SD51 Physical or electronic security failure
*SD53 Serious security breaches (eg escape, intruder, serious contraband)
ND70 Failure to utilise our resources to optimise excellent patient care and experience
*ND71 Failure to assess and manage the risk of aggression and violence effectively
FD97 Unmanaged smart telephones' access to The State Hospitals information and systems.

The following 22 risks are graded as Medium

*CE10 Severe breakdown in appropriate corporate governance

*CE11 Risk of patient injury occurring which is categorised as either extreme injury or death
CE12 Failure to utilise appropriate systems to learn from prior events internally and externally
MD32 Absconsion of patients
*MD33 Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)
*MD34 Lack of out of hours on site medical cover
MD35 Non-compliance with Falsified Medicines Directive
*SD50 Serious Security Incident
SD52 Resilience arrangements that are not fit for purpose
SD54 Climate change impact on The State Hospital
SD55 Negative impact of EU exit on the safe delivery of patient care within The State Hospital
SD56 Water Management
ND72 Failure to evolve the clinical model, implement and evidence the application of best practice in patient care
ND73 Lack of SRK trained staff
FD90 Failure to implement a sustainable long term model
FD91 IT system failure/breach
FD93 Failure to complete actions from Cat 1/2 reviews within appropriate timescale
FD94 Inadequate data centre
*FD96 Cyber Security/Data Protection Breach due to computer infection
HRD110 Failure to implement and continue to develop the workforce plan
*HRD111 Deliberate leaks of information
HR112 Compliance with Mandatory PMVA Level 2 Refresher Training

*target risk met

CE = Chief Executive
MD = Medical Director
SD = Security Director
ND = Nursing Director
FD = Finance Director
HRD = Human Resource Director

These risks are reviewed by risk owners (Directors) monthly and have action plans in place to assist reduction to their target level. All other risks fall into the review cycle detailed below:

Low risk	6 monthly
Medium risk	Quarterly
High risk	Monthly
Very High	Monthly*

*being reviewed weekly at present

Risk distribution of other risks are as follows:

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain				CE14	
Likely			ND70	MD30	
Possible			CE12, SD50, SD54, ND72, ND73, FD91, FD93, FD94	ND71, FD97	
Unlikely			MD33, MD35, SD55, FD90, FD96, HRD110	MD34, SD52, SD56, HR111, HRD112	SD51, SD53
Rare			FD95, CE13	MD32	CE10, CE11

4 RECOMMENDATION

The Corporate Risk Register Very High/High/Medium Risk report is presented to the Board for discussion, and to request whether any amendment is required to existing risks and/or whether additional areas should be considered.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Risk Management strategy of the Baord
Workforce Implications	As per report
Financial Implications	As per report
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested – reviewed through Risk, Finance & Performance Group
Risk Assessment (Outline any significant risks and associated mitigation)	As per report
Assessment of Impact on Stakeholder Experience	As per 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 ☑ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications , full DPIA included.

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
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Chief Executive	31/08/20	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	31/08/20	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	31/08/20	Risk, Finance & Performance 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	31/07/20	SMT	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 Almost Certain	Minor x Possible	Chief Executive	Chief Executive	08/06/20	SMT	Y/Y		Weekly
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	30/06//20	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	31/08/20	SMT	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	31/08/20	SMT	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	31/08/20	SMT	Y/Y	N/A	Quarterly
Corporate MD 35	Medical	Non-compliance with Falsified Medicines Directive	Moderate x Unlikely	Moderate x Unlikley	Moderate x Rare	Medical Director	Associate Medical Director	31/07/20	Medicines Committee	Y/Y	N/A	Quarterly

Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Moderate x Possible	Moderate x Possible	Security Director	Security Director	31/08/20	SMT	Y/Y	N/A	Quarterly
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Extreme x Unlikely	Extreme x Unlikely	Security Director	Security Director	30/06/20	Audit Committee	Y/Y	Y/Y	Monthly
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	31/08/20	SMT	Y/Y	N/A	Quarterly
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Unlikely	Extreme x Unlikely	Security Director	Security Director	30/06/20	Audit Committee	Y/Y	Y/Y	Monthly
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	31/08/20	SMT/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	30/06/20	SMT	Y/Y	N/A	Quarterly
Corporate SD 56	Service/Business Disruption	Water Management	Major x Unlikely	Major x Unlikely	Major x Rare	Security Director	Head of Estates and Facilities	31/07/20	Infection Control Committee	Y/Y	N/A	New
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	30/06/20	SMT	Y/Y	Y/Y	Monthly
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	30/06/20	SMT	Y/Y	Y/Y	Monthly
Corporate ND 72	Service/Business Disruption	Failure to evolve the clinical model, implement and evidence the application of best practice in patient care	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	29/02/20	SMT	Y/Y	N/A	Quarterly
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	31/08/20	PMVA Group and SMT	Y/Y	N/A	Quarterly
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	31/07/20	Audit Committee, RF&P Group & SMT	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	31/07/20	Information Governance Group & SMT	Y/Y	N/A	Quarterly
Corporate FD 93	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	31/07/20	CMT, SMT	Y/Y	N/A	Quarterly
Corporate FD 94	Service/Business Disruption	Inadequate data centre	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	31/08/20	SMT/Resilience Committee	Y/Y	N/A	Quarterly
Corporate FD 95	Service/Business Disruption	Lack of IT on-call arrangements	Moderate x Possible	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	31/12/20	SMT/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 Unlikely	Finance and Performance Director	Head of eHealth	31/07/20	SMT/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	Major x Possible	Major x Unlikely	Finance and Performance Director	Head of eHealth	30/06/20	Information Governance Group & SMT	Y/Y	Y/Y	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	31/08/20	SMT	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	31/08/20	SMT	Y/Y	Y/N	Monthly
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Major x Unlikely	Major x Rare	Interim HR Director	Training & Professional Development Manager	31/08/20	H&S Committee	Y/Y	N/A	Quarterly

Very High Graded
Actions from those not at target level

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.

- As this is a developing situation control measures are being looked at daily through the established command centre. In progress work is being monitored by the Covid-19 Support Team.
- Guidance being updated on a daily basis and being relayed to staff as soon it is can be.
- Implementation and further awareness of Test and Protect system.

High Graded
Actions from those not at target level

MD30 Failure to prevent/mitigate obesity

- Ongoing patient education and where appropriate restrictions/limits on additional food stuffs (snacks, takeaways, high energy food items and similar) being available out with meals in conjunction with 'Supporting Healthy choices' remit for those 'at high risk'.
- Workshop in January 2020 to scope work and changes required – step wise introduction of feasible changes post COVID pandemic.
- Review of cumulative effect of availability of food to patients and how this can be managed in a least restrictive manner to support patient's physical health.
- Increased accessibility of physical activity opportunities for all patients daily – move to national physical activity targets (min 150 minutes vs. 90).
- Increased education and training for staff around physical health needs – identified key support staff (trained and assistant proposed) to follow on from health champion posts in 2020 across the site supporting physical health matters.
- Ongoing implementation and audit of health and Wellbeing plans for 100% patients updated monthly and discussed at CPA's.
- Initiation of 'counterweight plus' (VLCD plans) in 2020 to targeted patients.
- Some of this work on hold due to COVID 19 pandemic.

ND70 Failure to utilise our resources to optimise excellent patient care and experience

- Recruitment to funded establishment
- Review of recruitment processes to streamline and minimise risks of gaps in workforce
- Review of roles and responsibilities regarding Nurse rostering and associated decision making
- Introduction of e-rostering platform
- Increase in staffing allocated to the nursing 'pool'
- Variation to shift pattern for new starts – 7.5 hour shift x 5 day
- Development of nursing element of workforce strategy
- Improved workforce information
- Recruitment of 'returners to practice.'

Paper No. 20/40

FD97 Unmanaged smart telephones' access to The State Hospital information and systems.

- Ongoing monitoring of increased security aspects of new phones introduced in 2019 – through 2020 – to ensure compliance and reduced likelihood of breach.

Paper No. 20/40
Medium Graded
Actions from those not at target level

CE12 Failure to utilise appropriate systems to learn from prior events internally and externally

- Await outcome of HIS notification process.

FD90 Failure to implement a sustainable long term financial model

- Review longer-term projections for sensitivities and potential budgetary pressures.

FD91 IT system failure/breach

- Increased use of DPIA to be encouraged and awareness raised.

FD93 Failure to complete actions from Cat 1/2 reviews within appropriate timescale

- Regular robust reporting arrangements required.

FD94 Inadequate data centre

- Replacement data centres in place April 2019 - now being closely monitored post-implementation. Further actions also now being addressed to introduce formal regular disaster recovery checking procedures (now underway in 2020 Qtr.1) and to reduce any identified unnecessary storage levels.

FD96 Cyber security/Data Protection breach due to computer infection.

At target level however:

- Cyber security training development ongoing.

SD52 Resilience arrangements that are not fit for purpose

- Increase frequency of testing programme.
- Completion of training plan for Incident Command.

SD54 Climate Change impact on the State Hospital

- Monitoring of climate change.
- Representation on NSS Sustainability Group (Head of Estates)
- Local sustainability group meetings.

SD55 Negative impact of EU exit on the safe delivery of patient care within The State Hospital

- Complying with national guidance re: communication to staff

- Maintain links with partner agencies regarding ongoing developments.

SD 56 Water Management

- Remedial work identified in L8 Risk Assessments to be completed

MD32 Absconsion of patients

No actions identified to reduce to target level – will be highlighted to risk owner.

MD35 Non-compliance with Falsified Medicines Directive

- NHS Lothian verification procedures to be in place before TSH implements own FMD. Likely end 2020.
- Standalone software and scanner required for TSH from JAC
- Identify location and staffing requirements within TSH for verification and decommissioning. Suitable training will be delivered.
- Register with Securmed for database link
- Standard operating procedures will be developed for process and how to deal with any 'fake' medicines identified. These should however have been picked up earlier in the NHS supply chain. Single SOPs for Scotland proposed.

ND72 Failure to evolve the clinical model, implement and evidence the application of best practice in patient care

- Implementation of agreed changes to clinical service delivery model during 2020/21.

ND73 Lack of SRK trained staff

- Training of all ward nursing staff in use of SRKs as part of PMVA training.

HRD 110

- No actions identified to reduce to target level – will be highlighted to risk owner.

HRD111 – Deliberate leaks of information

- Explore the potential to utilise the metacompliance system to ensure that all staff read the 'Protecting Patient Confidentiality NHS Scotland Code of Practice.

HR112 Compliance with Mandatory PMVA Level 2 Training

- Risk assessment to be completed in relation to Level 2 PMVA training delivery arrangements during the Covid-19 pandemic.