THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 17 JUNE 2021
at 12.30pm, held by MS Teams

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 15 April 2021	For Approval	TSH(M)21/03
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 21/37
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
12.50pm	**COVID-19 RESPONSE**		
7.	**Covid 19 Response and Remobilisation:**		
a.	**Resilience Update** Report by the Chief Executive	For Decision	Paper No. 21/38
b.	**Financial Update** Report by the Director of Finance & E-Health	For Noting	Paper No. 21/39
1.20pm	**CLINICAL GOVERNANCE**		
8.	**Clinical Governance Committee Annual Report 2020/21** Report by the Chair of the Committee	For Decision	Paper No. 21/40
9.	**Quality Assurance and Improvement** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 21/41
10.	**Clinical Governance Committee** Chair's Update – meeting held 6 May 2021 Approved Minutes – meeting held 11 February 2021	For Noting	 Verbal CGC(M)21/01
11.	**Clinical Forum** Chair's Update – meeting held 25 May 2021 Approved Minutes of meeting held 23 March 2021	For Noting	 Verbal CF(M) 21/02

1.45pm	**STAFF GOVERNANCE**		
12.	**Staff Governance Committee** **Annual Report 2020/21** Report by the Chair of the Committee	For Decision	Paper No. 21/42
13.	**Remuneration Committee** **Annual Report 2020/21** Report by the Chair of the Committee	For Decision	Paper No. 21/43
14.	**Attendance Performance Report** Report by the Interim Director of Human Resources and Staff Wellbeing	For Noting	Paper No. 21/44
15.	**Staff Governance Committee** Chair's Update – meeting held 20 May 2021 Approved Minutes – meeting held 18 February 2021		Verbal SGC(M) 21/01
	*** BREAK 2.10pm to 2.30pm***		
2.30pm	**CORPORATE GOVERNANCE**		
16.	**Update on the Report on the Annual Accounts – 1 April 2020 to 31 March 2021** Report by the Director of Finance & E-Health	For Noting	Verbal Paper No. 21/45 – deferred
17.	**Annual Review of Standing Documentation 2020/21** Report by the Director of Finance & E-Health/ Board Secretary	For Decision	Paper No. 21/46
18.	**Audit Committee** **Annual Report 2020/21** Report by the Chair of the Committee	For Decision	Paper No. 21/47
19.	**Finance Report to 30 April 2021** Report by the Director of Finance & E-Health	For Noting	Paper No. 21/48
20.	**Performance Annual Report 2020/21** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 21/49
21.	**Perimeter Security and Enhanced Internal Security Systems Project** - Update Report - Annual Report 2020/21 Reports by the Director of Security, Estates and Resilience	For Noting For Decision	Paper No. 21/50 Paper No. 21/51
22.	**Property and Asset Management Report** Report by the Director of Security, Estates and Resilience	For Noting	Verbal
23.	**Audit Committee** Chair's update – meeting held 17 June 2021 Approved Minutes - meeting held 25 March 2021	For Noting	Verbal A(M) 21/02

24.	**Corporate Risk Register** Report by the Director of Security, Estates and Resilience	For Decision	Paper No. 21/52
25.	**Any Other Business**		Verbal
26.	**Date of next meeting** 26 August 2021		Verbal
27.	**Proposal to move into Private session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal

Estimated end at 4.15pm

THE STATE HOSPITALS BOARD FOR SCOTLAND TSH (M) 21/03

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 15 April 2021.

This meeting was conducted virtually by way of MS Teams, and commenced at 10am.

Chair: David McConnell

Present:

Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Employee Director	Tom Hair
Chief Executive	Gary Jenkins
Director of Finance and eHealth	Robin McNaught
Non-Executive Director	Brian Moore
Non-Executive Director	Pam Radage
Director of Nursing, AHPs and Operations	Mark Richards
Medical Director	Lindsay Thomson

In attendance:

Person Centred Improvement Lead	Sandie Dickson [Item 8]
Chair of Clinical Forum	Sheila Howitt
Head of Communications	Caroline McCarron
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith [Minutes]
Director of Security, Resilience and Estates	David Walker
Interim Director of HR and Wellbeing	John White

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting, and no apologies were noted. He noted that the Board would be joined by Person Centred Improvement Lead for Item 8 on the agenda.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 25 February 2021 were noted to be an accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 25 February 2021: TSH(M)21/01

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 21/20) and noted progress on the action points from the last meeting, with actions either being completed or progressed satisfactorily.

The Board:

1. Noted the updated action list.

5 CHAIR'S REPORT

Mr McConnell provided an update to the Board in relation to the most recent meeting of the NHS Chairs' group which had taken place on 22 March and included a session with the Cabinet Secretary for Health and Sport, as well as a joint session with the NHS Scotland CEO group.

He confirmed that NHS Chairs had discussed progress made by the Corporate Governance Steering Group, and the link to the work on active governance being led through the Board Development team at NHS Education for Scotland. It had been noted that the NHS Scotland Blueprint for Good Governance had first been introduced in 2019 and that a review of this would be timely and led through the Corporate Governance Steering Group.

The NHS Chairs had also discussed the launch of the Independent National Whistleblowing Officer role, and Mr McConnell noted that an update in this respect for The State Hospital (TSH) was included in the agenda for this meeting. The Chairs group had also received an update on strategic workforce planning for NHS Scotland, focused on the broader impacts of the Covid-19 pandemic in this area and emphasising potential impacts on staff wellbeing as well as in equality and diversity.

The Cabinet Secretary and her team and Board Chief Executives had then joined the NHS Chairs group meeting and the Group offered their thanks and best wishes to the Cabinet Secretary, whose final meeting this was. It was also the final meeting of Mr John Connaghan the NHS Scotland Chief Operating Officer (COO), who was also thanked for his contribution. It was noted that Mr John Burns, currently Chief Executive Officer for NHS Ayrshire and Arran would take up the COO post in July 2021. Ms Freeman's team then provided updates in respect of the continued response to covid-19, in particular the rate of vaccination uptake nationally.

NHS Chairs received a presentation on the development of the NHS performance framework especially around waiting times and the delivery of services within the context of Covid-19, and how the NHS could respond in new ways during the remobilisation phase. This underlined the importance of engaging with the public, particularly given the potential challenges ahead. The group also received a presentation considering new approaches to leadership and how to delivery change in innovative ways, taking a whole system approach and placing leaders in NHS Scotland in the wider overall context of the public sector.

Finally, Mr McConnell noted the publication of the final report of the Independent Review of Forensic Mental Health, and that this was on the agenda in today's meeting.

The Board:

1. Noted this update from the Chair.

6a CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided an update to the Board on key national issues, since the date of the last Board meeting,

He provided an update on the work of the NHS Chief Executive group which continued to focus on the national response to Covid-19, as well as meeting more routinely through its business meetings.

Mr Jenkins confirmed that that the Board Chief Executives had reviewed the final report of the Independent Review into Forensic Mental Health, noting the potential impacts and need for scoping work to be initiated should the review proposals be accepted by the new Scottish Government administration. Further, that this should include the Forensic Network. Mr Jenkins confirmed that he would provide updates to the TSH Board in this respect going forward.

He outlined the key aspects of work being progressed through the NHS Chief Executives Group including re-drafting of the memorandum of understanding relating the to the GMS contract as well as the classification of Chief Officers in territorial boards and integrated joint boards as first responders. The group had considered the contractual arrangements for Office 365 for NHS Scotland noting the financial details as well as governance arrangements to ensure best value for NHS Scotland and an assurance that NHS Scotland would benefit from this and noting that further work would be progressed through the national Directors of Finance group. Board Chief Executives also received reporting in respect to cyber security and considered the need to develop a strategy for NHS Scotland. The group received the draft interventional radiology standards, as well as an update in respect of the Centre for Sustainable Delivery, established at NHS Golden Jubilee Hospital, to help deliver remobilisation of elective services.

Mr Jenkins advised that the mental health agenda had been very much to the fore at the Board Chief Executives group, and that he had introduced reporting to the group providing an assessment of current activity and performance standards including the challenges around improving access to services, delivery of care at the front door and through secondary care routes, distress intervention and the importance of early interventions. Further, the group noted the need for quality assurance linked to delivery of services and management of change. He noted the significant potential workforce challenges associated with the expansion of services.

Finally, Mr Jenkins noted the position on a new NHS pay deal for Agenda for Change staff which was currently being consulted on.

The Board:

1. Noted the update from the Chief Executive

6b INDEPENDENT REVIEW OF FORENSIC MENTAL HEALTH – FINAL REPORT

Mr Jenkins introduced this item, noting that the Board would be aware of the publication of the final report by the review chair, Mr Derek Barron. He indicated that since the date of publication of the report, an election period had commenced in relation to Scottish Parliament with the election taking place on 6 May 2021 leading to a newly constituted parliament and governmental administration. Therefore, the response to the report would follow after this date, with options being considered by the newly appointed ministers and cabinet.

The Board noted some key potential implications for TSH including the formation of a new national board for forensic mental health services across NHS Scotland, and the possibility of a return to women's high secure services being offered at TSH. The Board would discuss this at its next seminar session scheduled on 31 May 2021.

The Board also noted the recent publication of the Review of Adult Social Care services, which would similarly be considered by the new administration.

The Board:

1. Noted the update from the Chief Executive

7a RESILIENCE REPORTING – COVID 19 RESPONSE

A paper was received from the Chief Executive (Paper No. 21/21) to provide the Board with an overview of the way in which TSH was continuing to manage its response to Covid-19, and to provide key updates to the Board on actions taken since the date of the last Board meeting.

Mr Jenkins led the Board through the detail of the report noting that NHS Scotland would remain on an emergency footing until at least 30 June 2021. The position at TSH had remained stable with no further outbreaks or active infection within the hospital. He highlighted the review of the interim management structure, as outlined in the paper, and that the Corporate Management Team (CMT) had agreed to this structure being adopted permanently as well as noting further work to be developed internally to ensure that the management group structure was effective.

Mr Jenkins confirmed that at its latest meeting on 7 April, CMT had reviewed the TSH Route Map in detail, taking on board the recommendations from the TSH Scientific and Technical Advisory Group (STAG) to plan for changes in the delivery of services within the hospital aligning with the national framework of a gradual lifting of restrictions. A summary of the timetable was included in the report outlining the proposed changes from 19 April to 14 June 2021. Professor Thomson provided further detail for the Board on how these proposed changes had been considered and planned through STAG as well as the Operating Model Monitoring Group (OMMG) and keeping the delivery of therapeutic care for patients at the centre of planning.

Mr Jenkins confirmed that TSH would be ready to begin to resume in person visiting on 26 April 2021, using the Family Centre to do so, and taking into account the national guidelines in this regard. He highlighted the continuing successful rollout of vaccinations to both patients and staff at TSH. Mr Richards added that it was anticipated that this roll out would ensure a good coverage of vaccination for both patients and staff, further supporting the lifting of restrictions within the hospital. In answer to a query from Ms Radage about the potential impact of declined vaccinations, Professor Thomson confirmed that acceptance rates within TSH were 90% in both patients and staff and that therefore this risk had not presented to date.

In respect to the testing of NHS staff through the Lateral Flow Device (LFD) programme, Mr Jenkins advised the Board that TSH had been experiencing similar problems to other NHS Boards in terms of the national reporting requirements, with low uptake rates. He noted that this did not necessarily mean that staff were not conducting the tests, which were undertaken voluntarily, and that encouragement was being provided to staff to report their results. This programme included staff in patient-facing roles presently, and would be extended to all staff by the end of April. Mr Richards acknowledged the challenge in respect of the reporting requirement in a voluntary programme, and confirmed support and encouragement was being provided to staff through local LFD Champions as well as newsletters highlighting the way the LFD programme could provide reassurance to staff and their families as well as to patients.

Mr Jenkins confirmed that the improved position nationally had allowed a standing down of the general medical ward within TSH, though this type of care could be offered within TSH in future if required. The position on the availability of Personal Protective Equipment remained unproblematic for the hospital.

Mr Jenkins asked the Board to note the update on workforce matters including continuing focus on recruitment and personal development progress reporting. The Staff Wellbeing Service continued to provide a variety of support mechanisms to staff, as well as linking to the local community positively during what had been a difficult period for many people. Mr White emphasised the wealth of work underway in this area, and that it would be helpful for Non-Executive Directors to be able to interact with the service and see the range of activity underway.

There was agreement around the table on the high quality of reporting on the Covid response, as well as the effectiveness of support being offered to staff. Ms Fallon asked for further reporting on virtual visiting, especially benchmarking to other services in this area. Mr Jenkins confirmed that work was progressing in this respect and that further reporting would be presented to the Board. Mr

Currie offered the view in this regards that it was understandable that a cautious approach should be taken for TSH given the security constraints to be considered.

Action – Ms Smith/ Mr Walker

Ms Fallon asked if it would be possible to commence planning for the Board itself in terms of in person meetings as the national restrictions begun to be lifted. Mr Jenkins noted the extension of the emergency footing to the end of June, and that it may be that from July onwards a different direction could be possible; this could enable Non-Executive Directors to visit the TSH site as well to consider the organisational framework for public board meetings.

Ms Fallon noted the positon in respect of PDPR compliance and asked for assurance on this point, considering benchmarking to other NHS Boards. Mr White confirmed that the figure of 85.3% represented a good comparative performance in this area, and that it would not be possible for full compliance given the context of staff turnover and predictive absences (for example maternity leave).

Mr Moore raised the question of patient movement across the wider forensic network, and Professor Thomson advised that progress had been made, with the practice of virtual visiting prior to transfer supporting the process. At the same time, delays may occur, based on bed availability across the forensic estate. Mr Currie followed this up with a question on whether surge capacity could potentially affect TSH, and Mr Jenkins noted that TSH had continued admissions throughout the past year. The admissions criteria were based on forensic mental health needs of patients, and this was not expected to change significantly, although wider metal health support needs of the population as a whole had increased. Professor Thomson added that psychosis is a condition that required immediate reaction and that this has continued throughout the pandemic.

Mr Currie commended the vaccinations rates of 90% in both patient and staff, noting the support in the community especially from GP services to reassure patients and encourage uptake. Mr Currie also noted the importance of taking lessons from the Covid-19 experience, and placed this in the context of a new normal and different pace of working. He considered that there may be particular lessons for governance and that this may be impactful for TSH given the recent changes in board membership. Mr Jenkins concurred and noted the organisational development work carried out within the senior TSH leadership, and the need to provide development for Non-Executives Directors alongside that referencing the planning in place for board seminars throughout this year.

Mr McConnell summarised the discussion on behalf on the Board, and the view taken that this represented very good reporting which provided the necessary assurances to the Board especially in relation to the continued excellence in delivery of care. The report had been well discussed by the Board who were content to endorse the recommendations made.

<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 position as an appropriate framework for continued operational management and governance during the Covid-19 pandemic.

7b COVID -19 RESPONSE - FINANCIAL GOVERNANCE

A paper was received from the Finance and E-Health Director (Paper No. 20/22) to provide the Board with an update on financial governance to date, during the Covid-19 pandemic, including reporting of specific Covid-19 related costs to Scottish Government.

Mr McNaught advised that during February there had been consultation between Scottish Government and NHS Boards to look at expectations for Covid-19 related costs for the final quarter of the year – if costs were less than anticipated then there would be an element of handback. For

TSH, following this there was a meeting with Scottish Government to review the Quarter 3 and Quarter 4 positions and to review the forecast outturn. He confirmed that for TSH, it had been agreed that Covid-19 additional funding would be offset against additional staff payments for the agreed bonus and the 1% pay advance announced. He outlined the positon for reporting Covid-19 costs for 2021/22 which will be reported through Quarters 1 and 2 with further confirmation on this process to follow.

Mr McConnell confirmed the Board's positon as being content with this update on financial governance, with further reporting in this area to be presented at the next meeting of the Board.

The Board:

1. Noted the updated advice on financial governance through the Covid-19 pandemic.

7c RECOVERY AND INNOVATION – UPDATE

A paper was received from the Head of Corporate Planning and Business Support (Paper No. 20/23) to provide assurance to the Board on the progress of work and key areas of achievement during the Covid-19 period.

Ms Merson outlined the process undertaken to engage staff and take key learnings, emphasising the overall impression that staff were keen to pursue a process of change. Initially this workstream was taken forward by a dedicated short life working group, and leadership in this area had transferred to the HR and Wellbeing Group. She described the key themes and areas of activity flowing from these across the organisation. The way forward now would be focussed within directorate structures and through the line manager framework thus ensuring that the recovery and innovation agenda was firmly embedded in how TSH operated.

Ms Fallon commended the work progressed and added a query as to how this had ben costed in terms of workforce skills as well as any financial impacts. Ms Merson noted that the skills framework used had been the RSA framework; and Mr Jenkins added that this framework had provided an opportunity to assess organisational practice and re-consider these thus empowering staff. In respect of financial costings, this had been taken forward separately under costs relating directly to Covid-19.

Mr Moore commended the positive nature of the report, especially the focus on patient outcomes and how to embed the benefits and lessons learned as part of this process into organisational practice.

Mr McConnell summarised the discussion, noting the positive reception from the Board especially around the development of new ways of thinking in this forward looking workstream.

The Board:

1. Noted the progress report in the recovery and innovation workstream.

8 PATIENT STORY: "NU TO U"

The Director of Nursing, AHPs and Operations introduced a presentation from the Person Centred Improvement Lead in relation to taking learning from patient feedback, relating to recycling clothing within the hospital.

Ms Dickson joined the meeting – explaining that this was an initiative taken forward from on original discussion from patients in the patient partnership group. She noted the income differentials between patients depending on their circumstances, as well as a lack of access to charity shops for reasonably priced clothing, in the way that the general populace may have. She noted that, due to

the circumstances, some patients can be admitted to the hospital with very little clothing or personal items. Patients had suggested setting up a charity shop within the hospital, and this was under planning to be taken forward this year. However, in the meantime a clothing bank had been set up. This accepted clothing donations and patients could access it through referral from the clinical team and at no cost. Mr Richards then outlined the ways in which this workstream could have wider benefits for patients in a rehabilitation context, supporting patients and building skills through this process.

There was agreement around the table that this was an excellent initiative, that it met a recognised need in patients as well as supporting a rehabilitative framework of care.

Mr McConnell summarised for the Board, noting the practical response to a new and interesting idea from the Patient Partnership Group.

The Board:

1. Noted the update – with a positive and beneficial initiative put into practice based upon patient feedback.

9 SUPPORTING HEALTHY CHOICES – DRAFT WORKPLAN

The Board received a paper from the Medical Director (Paper No. 20/24) to provide an update to the Board, following its last meeting.

Professor Thomson provided an overview of the draft workplan for the Board, and emphasised that this was a key area clinically to meet the physical health needs of patients and drive improvement in patient weight. In March 2021, 89.9% of the TSH patient population were overweight or obese. She also drew the Board's attention to a recent publication by Public Health England in recognition of this problem in high secure settings "Managing a healthy weight in adult secure services – practice guidance (February 2021). Within TSH, this workstream was being led through the Supporting Healthy Choices Group.

Professor Thomson provided an overview of the plan, explaining that the patient population could be split into two overarching groupings – those who develop weight gain during their admission to TSH (indicating a need to focus on prevention) and those who were already overweight or obese at the point of admission (indicating a need to focus on treatment or reduction). She highlighted the key areas of focus within the plan, which was based on realistic medicine principles, and outlined the proposed way forward to drive improvement in this area. The plan would be subject to a consultative process to ensure wider stakeholder input.

The Board discussed the draft plan in detail, with agreement around the table on the importance of this workstream and the need to seek pathways for improvement. Brian Moore asked for further clarification on the wider approach taken around patient engagement and how this was effected. Professor Thomson concurred on the importance of this, especially given the obesogenic environment for patients within TSH, and that consideration should be given to opportunities to improve these factors. She emphasised the ways in which patients were engaged through their individual health and wellbeing plans.

Mr Currie followed this point by underlining the importance of supporting patients to make healthier choices, gaining their commitment to adhere to their health and wellbeing plans. He noted wider societal actions such as re-considering access to products in a public health context. Ms Fallon noted the importance of ensuring that key workers were empowered to fulfil their responsibilities to support patients. She also asked for further information on success stories in similar environments. Professor Thomson noted that although limited success had been found in some cases, there was not yet widely reported success in similar environments. Further, that some secure environments had reviewed access to products as a possible means for changing the obesogenic environment – this was in the context of a balance between the Board's duty of care and personal choice on the

part of patients.

Mr Jenkins highlighted that this was a complex area in which improvement had not been made over the past five years; new ideas and wider initiatives may now be required especially in relation to changing the environmental opportunities for patients. This had been experienced during Covid-19 – for example patients had enjoyed the opportunity to cycle in the hospital grounds. Mr Richards concurred and emphasised the need to focus on high impact actions. He added that the workforce contribution would be essential in supporting patients in their weight loss journeys and to help to promote change, especially through health psychology as well as activity coordinators.

Ms Radage underlined the need for intervention in this area to help support patients, and asked for some feedback on how the patient group themselves feel about this issue. Professor Thomson noted generally patients were seeking a healthier way of life, and that weight gain often caused difficulty with self-esteem.

There was detailed discussion around the table on the timescales contained within the plan, with recognition that the plan needed to be ambitious and to seek to put into effect change over a relatively short period of time. At the same time, there needed to be realistic assessment of this, and that specific, short–term measurable milestones would be the most effective way to bring forward demonstrable change. Mr Jenkins noted that the expectation was that the new clinical model could be reviewed for implementation during 2021, subject to the developing Covid-19 situation over this period. This would be an opportunity to harness learning and consider new approaches to both the physical as well as the mental health needs of patients.

Mr McConnell summed up this discussion for the Board and its view that this was an extremely important area of focus over the coming year.

The Board:

1. Noted the content of the report, including the progress made by the Supporting Healthy Choices Group.
2. Reviewed the draft plan and considered the practice guidelines issued by Public Health England.
3. Noted that further reporting on progress would come to the Board as part of its workplan.

10 NURSING REVALIDATION REPORT

The Board received a paper from the Director of Nursing, AHPs and Operations (Paper No. 21/25) which outlined the process in place for monitoring professional registration status of nurses working at TSH, during 2020/21. Mr Richards outlined the detail of the report, confirming that no staff member's registration had lapsed during this time period.

The Board:

1. Noted the content of the report.

11 QUALITY ASSURANCE AND IMPROVEMENT REPORT

A paper was received from the Head of Corporate Planning and Business Support (Paper No. 21/26) to give the Board a regular update on the progress made toward quality assurance (QA) and Quality Improvement (QI) activities in the period since the date of the last Board meeting.

Ms Merson provided a summary of activity including clinical audit, learning from complaints, quality improvement through the work of the Quality Forum as well as evidence for quality within TSH including analysis of national and local standards and guidance issued (with relevance to TSH). She highlighted the progress made in realistic medicine with a review meeting held with Scottish

Government leads in this area, which had brought positive feedback on TSH planning.

Mr McConnell summed up for the Board, noting the value and usefulness of this reporting.

The Board:

1. Noted the content of the report.

12 CLINICAL FORUM

The Board received the agreed minutes of the meeting of the TSH Clinical Forum which took place on 26 January 2021.

Dr Sheila Howitt, Chair of the Clinical Forum, provided an update to the Board on the activities of this group including their most recent meeting on 23 March 2021. The Forum was continuing to develop well and strengthen its role in the hospital as a multi-disciplinary advisory group.

The Forum had recently been focussing on the issue of digital inclusion for patients and their carers; as well as aspects of the prevention and management of violence and aggression within a high secure setting, and the use of Personal Protective Equipment. She advised that as Chair of the TSH Forum, she was a member of the National Areas Clinical Forum Chairs' Group and this was a useful resource through which to engage on a national level.

Ms Fallon noted that the minute referred to a gap in patient physical care and asked for further clarification. Dr Howitt provided further background to this, which related to the GP service within the Health Centre, noting that review of this had been undertaken and temporary arrangements put in place as a result to support patient needs.

Mr McConnell thanked Dr Howitt for this very helpful update on the work of the group as well as the links made at a national level.

The Board:

1. Noted the content of the update from the Clinical Forum.

13 TSH INTERIM WORKFORCE PLAN 2021/22

The Board received a paper from the Interim Director of Human Resources and Wellbeing (Paper No. 21/27) which outlined the position on the Interim Workforce Plan for TSH for 2021/22. Mr White provided a summary of this for the Board, including the detail of the Revised Workforce Planning guidance published by Scottish Government. This recognised the significant ongoing challenges faced by NHS Boards during the Covid-19 pandemic to deliver a three-year plan. Therefore, a one-year interim plan was required.

He highlighted the main component part of the TSH plan, particularly the need for synchronicity with the TSH Remobilisation Plan for 2020/21. Work on the plan had been progressed through the CMT as well as the HR and Wellbeing Group and the Partnership Forum, ensuring a wide range of stakeholder input, and that staff wellbeing was very rightly a key focus of the plan.

Mr White noted the short and medium term drivers of this one-year plan including the Health and Care(Staffing) (Scotland) Act 2019 and the potential for a female patient provision within TSH, and the implementation of the new clinical model. He also emphasised the continuing work to engage with staff and to take the temperature of the organisation through the recovery and innovation workstream, as well as the repeat of the TSH staff survey which was currently underway. The wide range of activity focused on staff wellbeing had meant that this was more wide-ranging and straddled a number of different areas in the hospital than previously, when the key focus had been more keenly

on attendance management due to the specific concerns in that area.

In answer to a query from Mr McConnell, Mr White confirmed that national guidance for this one-year plan was not on the traditional approach detailing staff numbers and groups but that the expectation was that this would be required in the next workforce plan, which would be phased over three years. Mr Fallon asked for clarification on provision for assessment for the health and safety of staff who were working from home, and Mr White confirmed that a process for individual risk assessment was in place through the homeworking policy. Mr Currie commended the plan for its accessibility and asked for some further assurance around implementation of the plan – and asked if there were there any risks for TSH or additional support mechanisms needed to ensure that the plan could be taken forward. Mr White confirmed that this demonstrated the value of a one-year plan in the current climate as this lent additional flexibility for workforce planning and emphasised the need to focus on recovery. He considered that the plan could be delivered for TSH, whilst at the same time noting that there were some unknowns in year - most specifically any short term impacts of the Review of the Delivery of Forensic Mental Health should the recommendations contained within it be accepted and taken forward.

Mr McConnell summarised the discussion for the Board on the plan which had been positively received, and approved as a helpful in line with remobilisation and recovery planning. He noted that the plan should be submitted to Scottish Government by the due date of 30 April 2021.

The Board:

1. Approved the TSH Interim Workforce Plan 2021/22.
2. Noted that the TSH Interim Workforce Plan would be submitted to Scottish Government by 30 April 2021.

14 ATTENDANCE PERFORMANCE REPORT

The Board received a paper from the Interim Director of Human Resources and Wellbeing (Paper No. 21/28) outlining the position on staff attendance for the period up to 31 January 2021.

Mr White outlined the key highlights from the report, which demonstrated a continued positive picture for the organisation in this regard, most particularly for a sickness absence rate of 4.89 % for January 2021 which fell within the target rate of 5%. The report also placed this performance within the national context.

There was general agreement from Board Members that this represented continued improvement, however, concern was noted regarding the data on long-term sickness absence. Mr White provided some further background on this explaining that historically the picture at TSH had been for an even split between short and long term sickness absence. There had been success in reducing short term absences and tools used to do so included the EASY programme. The need to focus on the reason that lay behind long term absences (i.e. those in excess of 28 days) was recognised and work was progressing to support staff and line managers in this, with some improvement seen in the past three months. Mr White advised that it was helpful to take learning from other NHS Boards who had had success particularly in reducing long term absence, and work was underway to do so. Although all NHS Boards worked to the same policy framework, it could be that learning could be taken from the ways in which interventions were being managed locally.

Mr Currie noted the additional potential challenge in a smaller organisation like TSH in that fewer opportunities may exist to redeploy staff in order to support them back to work as soon as possible. Mr Hair added that it would be beneficial to focus in particular on individual departments or areas in the organisation who may be experiencing higher levels of long-term absence.

Mr McConnell summarised by noting the very positive nature of the report overall, and that the Board appreciated the effort and successes of staff and managers across TSH.

The Board:

1. Noted the content of the report, and continued progress in this regard.

15 INDEPENDENT NATIONAL WHISTLEBLOWING OFFICER LAUNCH – UPDATE

The Board received a paper from the Interim Director of Human Resources and Wellbeing (Paper No. 21/29) which provided an update on the launch of the Independent National Whistleblowing Officer with effect from 1 April 2021, as well as the local preparation progressed at TSH in readiness for the launch with compliance at TSH with the new policy.

Mr White noted the local mechanisms in place to promote this launch including online briefing sessions for line managers as well as access to online training modules. As the Board's Whistleblowing Champion, Mr Moore advised that a network group had been formed across NHS Scotland for NHS Board Whistleblowing Champions which would meet monthly. He commended the work progressed at TSH in this regard and thanked the Human Resources team for ensuring that that TSH was well prepared for the implementation of the new policy. This was echoed by Ms Radage and Ms Fallon, along with a query on how this would be refreshed in the future. Mr White confirmed that regular updates would be reported through the Staff Governance Committee as well as to the Board directly.

Mr McConnell summed up the positon in that the Board was content to note this reporting and that more detailed oversight in this area was being led by the Staff Governance Committee. There would be monitoring of uptake of online training particularly for line managers, identified as having an essential role in supporting the policy within TSH, and also supplementary communications bulletins to all staff for their awareness and understanding. He noted that the Board were content with the good progress made in this regard.

The Board:

1. Noted the content of this report including compliance with national policy.

16 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

A report was received from the Director of Security, Resilience and Estates (Paper No. 21/30) in relation to the Perimeter Security and Enhanced Internal Security Systems Project.

Mr Walker presented this update to the Board, asked members to note that the project was proceeding according to projected planning. He highlighted the factory acceptance testing which had taken place at the end of March, had shown failures minor areas only which were capable of resolution through the main contractor and would have no cost implications for TSH. A mid-programme strategic review had taken place which indicated that a reviewed completion date on the end of January 2022 was likely, with the contract end date being March 2022. This reflected the impact of Covid-19 as well as the required change to the programme for Running Track CCTV.

Mr Jenkins added his assurance to the TSH Board in the progress and oversight of this project through the Project Oversight Board which continued to fulfil due diligence in considering every part of the project and assessing any potential risks for TSH.

Ms Fallon asked for some clarification on the factory acceptance failure for Personal Attack Alarms (PAAs) and Mr Walker provided confirmation that this did not relate to the existing system but to the newly configured replacement system and was capable of resolution.

Mr Walker advised that a further report would be submitted to the private session of the Board, due to the commercial sensitivity and level of security information involved, meaning that that reporting would not be appropriate in the public domain. Mr McConnell noted the position for the Board.

The Board:

1. Noted the content of this report.
2. Agreed to further reporting being made in a private session of the Board due to the commercial sensitivity and security issues.

17 FINANCE REPORT AS AT 28 FEBRUARY 2021

A paper was submitted to the Board (Paper No. 21/31) by the Finance and eHealth Director, which presented the financial position to Month 11 (28 February 2021).

Mr McNaught summarised the report, outlining the Board's financial position, and confirmed that TSH was reporting an underspend at this date of £0.519m, and that the capital budget was expected to be fully utilised. A break-even positon continued to be predicted for this financial year.

He confirmed that work was progressing well in respect to the savings plan and budgets for 2021/22, as well as in respect of three-year financial planning. He also highlighted the work underway with Scottish Government relating to capital planning for the coming year and that a further detailed report would be brought to the next Board meeting.

Mr McConnell confirmed that the Board were content to note this paper.

The Board:

1. Noted the content of this report.

18 DIGITAL TRANSFORMATION – UPDATE

A report was received from the Finance and eHealth Director (Paper No. 21/32) which provided an update on the ongoing digital transformation agenda within TSH.

Mr McNaught emphasised the importance of this workstream for TSH, and described some of the key areas of activity. This included rollout of the national Office 365 project, and the introduction of the Tableau Business Intelligence system. In addition, the eHealth team continued to provide day to day user support through the Helpdesk, which had experienced an increase in demand related to the continuing need for remote working.

Mr McConnell confirmed that the Board were content to note this paper.

The Board:

1. Noted the content of this report.

19 CORPORATE GOVERNANCE IMPROVEMENT PLAN

The Board received a paper from the Board Secretary (Paper No. 21/33) which provided an update on the progress of activity in this area, most particularly the key areas highlighted within the report which would be developed during the coming year.

Ms Smith asked the Board to consider these areas in particular, including work with the National Workforce team in relation to nurse rostering, being taken forward in the context of Health and Care Safe Staffing legislation; as well as the ongoing review of performance metrics across the organisations. She also noted the development work being progressed in relation to both the recovery and innovation and risk reporting workstreams with update reports on each included in this meeting's agenda. In addition, there was continued progress on the development of digital

platforms and how this could be linked to senior leadership visibility.

Ms Smith noted that two areas could be considered for closure on this plan, with work on recruitment initiatives as well as the launch of the new whistleblowing policy well embedded in wider reporting to the Board.

Although this related to a self-assessment exercise undertaken in 2019, Ms Smith asked this newly constituted TSH Board for any further areas they considered would benefit by being included in this plan.

Mr McConnell confirmed for the Board that they were content to accept the updated plan, and the recommendation to close the items indicated. The Board did not recommend any further areas for inclusion in the plan at this stage.

The Board:

1. Noted and agreed the direction of travel of the plan as presented, including closure of the items indicated.

20 AUDIT COMMITTEE

Mr Moore asked the Board to note the meeting that took place on 25 March 2021, as well as the approved minutes of the meeting which had taken place on 21 January 2021.

The Board:

1. Noted an update on the meeting on 25 March 2021, and the approved minutes of the meeting which took place on 21 January 2021

21 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 21/34) from the Director of Security, Estates and Resilience, 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. In addition, reporting was submitted to the Board to provide an update on progress in review of local registers and the link from these to the Corporate Risk Register.

Mr Walker presented these updates to the Board, and highlighted the key point that the corporate risk specifically relating to the impact of Covid-19 on TSH was being reviewed in detail by CMT to consider whether it would be possible to reduce this. He described the work underway to develop the local risk registers held across the hospital, and to put in place a clearer process for the escalation or de-escalation of risk, and how this was managed in the organisation.

Mr McConnell confirmed that the Board noted the report and did not consider that discussion at today's meeting had indicated that any further amendment or addition should be made to the Corporate Risk Register. In addition, the Board was content to note the progress made in relation to the management of risk registers.

The Board:

1. Noted the content of this report, including progress made in the management of local risk registers.

22 ANY OTHER BUSINESS

There were no further competent areas of business for discussion at this meeting.

23 DATE AND TIME OF NEXT MEETING

The next public meeting would take place on Thursday 17 June 2021, by way of MS Teams.

24 PROPOSAL TO MOVE TO PRIVATE SESSION

The Board then considered and approved a motion to exclude the public and press during consideration of the items listed as Part II of the Agenda in view of the confidential nature of the business to be transacted.

The meeting ended at 2.45pm

ADOPTED BY THE BOARD

CHAIR

DATE

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 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	Paused in April 2020 – now restarted with update on progress to Board – August 2021	**Considered as part of Board Seminar (May 31st) and agreement to preparatory work for re-start of implementation during 2021. Further reporting with workplan to be reported back to the Board.**
2	October 2020	Corporate Risk Register (Item 23)	To track risks no on target for timescales and actions taken direction of travel and include in regular reporting	D Walker	April 2021	**Completed at meeting on 15 April – to be closed**
4	February 2021/April 2021	Resilience Report – Covid-19 (Item 7a)	Provide benchmarking comparison to other organisations on use of virtual visiting	R McNaught/ D Walker	June 2021	**Considered at 15 April meeting – further updates requested. Update is included in Covid response report at Item 7a**

5	February 2021	Resilience Report – Covid-19 (Item 7a)	Provide further detail on actions taken for on PDPRs	J White	April 2021	**Reported and considered at 15 April meeting – to be closed.**
6	February 2021	Attendance Management Report (Item 15)	Add board's sickness absence target (5%) to table 3. Provide document map of this report to board and standing committees.	J White	April 2021	**Reported at 15 April meeting – to be closed**
8	February 2021	Board Public Meetings (Item 23)	Review route to enable this and if possible to route to patient cohort	M Smith	August 2021	**Update: Blend of in person / virtual meetings for the Board (Covid Route map dependent)** **To progress along with virtual engagement for patients, further update to follow.**

Updated – 10.06.21 – M Smith

Author:
Margaret Smith
Board Secretary
01555 842012

Paper No 21/38

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Reference:	Item No: 7a
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	TSH Response to Covid 19 Global Pandemic – Update
Purpose of Report:	For Decision

1 SITUATION

This report provides an update to the Board on the continuing response to the global Covid-19 pandemic by The State Hospital (TSH) by prioritisation of strategies to protect the health and wellbeing of both patients and staff; and to minimise as far as possible the risk of transmission of the virus through staff and patient populations.

The Board has received reports at each of its meetings throughout the pandemic, to set out the actions taken as well as remobilisation planning. The TSH Remobilisation Plan, for the period 1 April 2021 to 31 March 2022, has received approval from Scottish Government and has been published on the TSH website. Given the changing position nationally and globally, It is expected that remobilisation planning will be further developed during this year, and therefore further reporting will be brought to the Board. On 18 March 2021, it was confirmed in a statement to the Scottish Parliament that NHS Scotland would remain on an emergency footing until at least 30 June 2021. Further national guidance in this area is awaited.

2 BACKGROUND

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

2.1 Senior Leadership and Management Structure

The phased move to a new management structure was completed in April 2021, and the effectiveness of this will be kept under close review to support further development of the wider leadership structure across the organisation. To date, this has focussed in particular on the Hospital Management Team with structured input from the Organisational Development Lead and a dedicated workshop arranged to take place on 16 June 2021. Aligned to this, the Board Secretary will continue to undertake a review of the whole system with particular focus on how the system supports effective decision-making and the flow of actions. The Corporate

Services Team supports the management structure, led through the Board Secretary. In addition, there is dedicated support for the response to Covid-19, from infection control, risk management, operational management and human resources.

The process of reviewing and implementing national guidance from UK Government, Scottish Government and Professional Bodies continues to be tracked and reviewed through the Scientific and Technical Advisory Group (STAG) reporting to the Corporate Management Team (CMT).

3 ASSESSMENT

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

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

The Board is aware that delivery of care throughout the pandemic has been managed through the TSH Route Map and the Clinical and Support Services Operational Policy. The aim has been to effect a phased remobilisation to support rehabilitative and therapeutic activity for TSH patients.

At its last meeting, the Board received reporting on the planned moves through the TSH Route Map for the period to 14 June. As part of this plan by 14 June, there will be no requirement for physical distancing among the patient group and all activities within the Skye Centre can resume subject to capacity constraints. The Route Map has planned that from 14 June, all patients can mix in the hospital grounds and the Skye Centre, with groups and activities involving patients from different Hubs. This will focus on all types of activity to help re-engage patients and support them through this transition. The emphasis is on encouraging patients to re-engage with the increasing range of possible activities.

All phased changes in line with the TSH Route Map have been managed subject to an emphasis that activities can continue to operate in a Covid 19 secure fashion, by adhering to standard operating procedures developed to keep staff and patients safe. Oversight of this is taken through the STAG and the CMT.

The Interim Clinical Operational Policy remains subject to regular scrutiny and review, underpinned by data gathering and reporting undertaken by the Clinical Effectiveness Team, and a formal fortnightly review meeting through the Operating Model Monitoring Group. This results in a recommendation to the CMT 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 meaningful activities, including access to fresh air and participation in exercise. At the last meeting of the OMMG it was noted that all patients in the hospital had access to fresh air, physical activity or a timetabled activity session.

3.2 Infection Control

Infection prevention and control remains central to the response to Covid-19 within TSH. The Board is aware that the Senior Nurse for Infection Control is part of the internal Covid-19 response team and receives external support from the Public Health team in NHS Lanarkshire. In addition, recruitment is underway for another member of the infection control team to add resilience for the organisation in this area.

A programme of Covid-19 secure audit work is being carried out – with dedicated staff resourcing in place to support this essential work. This encompasses both clinical and non-clinical areas, and monitoring through the STAG and the CMT. This programme takes account of practice changes and the phased remobilisation of services and activity in the hospital. All changes to practice are reviewed by the STAG, and the Infection Control Committee continues to meet regularly. Since the date of the last Board meeting, there have been no confirmed cases of Covid-19 within the patient population in TSH.

Should a patient be symptomatic and require testing, practice is to isolate the relevant ward and to carry out contact tracing for that patient. This is whilst testing of the patient is conducted and reported upon. To ensure that results of patents can be received as quickly as possible, point of care testing means (including rapid testing) are currently being investigated for implementation. However, the default position at this point remains a PCR test.

Table 2: Number of Patient tests, positive and negative results

December 2020 – May 2021

Month	Dec	Jan	Feb	March	April	May
Total Tests	9	57	60	22	11	16
Asymptomatic tests	8	52	59	20	11	15
Positive results	0	4	2	0	0	0
Negative results	9	53	58	22	11	16

Table 3: State Hospital Staff tests by result, for national test centre results

Date to end of 31 May 2021

	Number	% of Total Staff population (n=650)
Staff tests	243	37%
Positive test results	41	6%
Negative test results	194	29%

3.3 Virtual and In Person Visiting

In Person Visiting

In line with national guidance and as detailed in the TSH Route Map, visiting in person recommenced at TSH on 26 April 2021. The Family Centre has been utilised to support this with separate arrangements in place for those patients who would not be able to be able to move from their ward area for visiting. This has been received well by patients and carers, who have each provided positive feedback.

This programme of visiting is facilitated through encouraging visitors to undertake Lateral Flow Device (LFD) Testing, on a voluntary basis to help support infection control within the hospital.

In addition, volunteer visiting has now resumed and this is a further means of supporting patients, particularly those who may not receive any other form of visiting. There are eight volunteer visitors and they are able to carry out in person visiting, subject to being at least

three weeks post second vaccination and to carrying out LFD testing to demonstrate a negative result on the morning of their visit.

Virtual Visiting
Throughout the pandemic, TSH has also focussed on digital means to ensure that an alternative solution has been available to patients and their families and carers to continue to connect when in person visiting has not been possible. This service remains in place and use has remained consistent. It has no direct cost other than the purchase of the equipment and is a secure platform that is provided and managed by the national NHS video-conferencing team.

Work has been progressed to compare and benchmark use of video visiting in TSH to other NHS Boards – however, this type of visiting through the video-conferencing is unique to TSH and is not used elsewhere in NHS Scotland. Given this, further information has been sought from similar high secure hospitals in NHS England to explore whether a meaningful comparison of activity can be taken.

Additionally, an alternative solution to video-conferencing has been identified, which is in use elsewhere in other secure organisations across the U.K. and which may bring additional capability to control and manage video calls locally. A Short Life Working group was formed to facilitate a small ''Proof of Concept'' trial as a recommended first step. This will also provide a means to gauge how patients, staff and carers feel about using the alternative system. Further reporting will be routed through the CMT, with the Board being kept advised of developments in this area.

3.4 Covid-19 Vaccination Programme

TSH has undertaken a programme of vaccination for both patients and staff as part of the national roll out of the Covid–19 vaccination programme.

3.4.1 Staff
In line with the JCVI guidelines, staff were identified who work in roles where they have direct care contacts with patients such as nursing and medical staff; and where they work in roles that require them to work in patient settings, such as housekeepers. During the months of March to May, all eligible staff have been offered the vaccine and 88% of staff in this cohort having been fully vaccinated, with a small cohort declining the vaccine.

This figure does not include staff who have been vaccinated by their local NHS Board through the national vaccination programme.

3.4.2 Patients
The roll out of the vaccine to patients has continued, with second doses delivered in the week beginning 24 May – this has resulted in over 90% of patients being vaccinated. A small number of patients have to date declined the vaccine, and they will be advised of the risks of doing so. This is being carried out with the careful involvement of their Responsible Medical Officer to ensure that this advice is provided appropriately, dependent on each individual patent's circumstances.

The vaccine programme within TSH is being managed to ensure that there is a minimum of vaccine wastage.

3.5 Test and Protect

In line with all other NHS Boards, TSH began a programme to coordinate implementation of LFD testing at a local level, commencing on 28 December 2020. This was originally focussed on patient-facing healthcare workers, but has now been extended to all staff, aligning with the availability of this type of testing to the general public including secondary school age children.

This self-testing is on a voluntary basis, and all staff are encouraged to undertake and register their test results on a twice weekly basis. NHS Boards are asked to report testing levels each week, as well as positivity rates. Within TSH, progress reporting is submitted through the STAG and the CMT. The testing rate for TSH for number of LFD tests (reported as a percentage of the expected overall number of tests) for the week to 3 June 2021 was 18% approximately, and this sits below the national average of 26%. To support the LFD testing programme, an improvement plan was developed and submitted to Scottish Government on 20 May, including the implementation and delivery of testing and the roll out of communication and support for staff to do so. The plan was signed by the Chair on behalf of the Board, and can be made available to members for further background in this area.

In addition, TSH requires all contractors coming on site to undertake LFD testing. Auditing of this has continued and monitoring reporting is submitted to the STAG, as well as to the CMT and the Project Oversight Board. No issues have been noted with uptake and management of this control measure.

3.6 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**.** A six bed General Medical ward was established and equipped to accept any patient who required enhanced care for symptoms of Covid-19, and could not be transferred to an acute hospital. Although it was not necessary to use this facility, it remained in place until the end of March 2021. TSH remains equipped with oxygen supplies and ready to respond should any patient require enhanced care for symptoms of Covid-19 to be delivered on site.

3.7 Personal Protective Equipment

TSH continues to be linked with National Services Scotland (NSS) through procurement. To date, there have been no issues with stock availability on site. PPE usage and the availability of supplies are monitored daily. Escalation routes remain available through the TSH Single Point of Contact (SPOC), the Director of Security, Estates and Resilience, and through NSS Covid-19 Supplies Portal.

The programme to re-fit clinical staff with FFP3 masks, due to the expiry of two models of mask, has continued successfully with a small number (18 approx.) outstanding at the time of reporting. All relevant staff will have been re-tested and fitted for a FFP3 mask before the deadline for this of 30 June 2021.

There continues to be no supply or cost impact for TSH since the withdrawal of the U.K from the European Union on 31 January 2021, and this area is monitored continually through the Director of Security, Resilience and Estates.

3.8 Patient Flow

As part of the wider forensic network, TSH continues to be linked in collaborative work with medium and low security care providers, and in conjunction with Scottish Government Mental Health Directorate, focussed on the challenge of Covid-19. This includes admission to, and transfer between, secure mental health services, suspension of detention and preparation for moving into the community.

The following table outlines the high level position from 1 April to 31 May 2021.

Table 4: Patient flow 1 April to 31 May 2021

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	5	0	5
Discharges / Transfers	5	0	5
Average Bed Occupancy: Available beds/All beds			93.5% **/** 80.1%

3.9 Workforce

3.9.1 Attendance Management

The Board now receives dedicated reporting in this area, including Covid-19 related absence.

3.9.2 Planning for Extreme Loss of Staff

The Extreme Loss of Staff Plan for TSH was developed at the start of the pandemic, in response to a significant threat to business continuity as a result of the coronavirus pandemic. A level 2 resilience exercise was held to stress test this plan and provided assurance on preparedness at a local level. This remains a focus to ensure that local knowledge is refreshed regularly.

3.9.3 Staff Recruitment

Human Resources have continued to take forward the recruitment process for all confirmed positions with appointments made across a range of disciplines. There are currently 42 posts actively moving through the recruitment process from the following departments: Infection Control, Nursing, eHealth, Clinical Operations, Skye Centre Nursing, Medical, Psychology, Security, Housekeeping, Catering, Research & Development, AHPs, Procurement, and the Executive Team.

Since the date of the last Board meeting, recruitment activity has concluded for posts within Ward Based Nursing, Skye Centre Nursing, Security, Estates, and Risk & Resilience.

3.9.4 Staff Wellbeing

Staff Wellbeing continues to be prioritised throughout the Covid-19 pandemic, with a focus on how to support and maintain staff health and wellbeing during this period of significant challenge. The Professional Nurse Advisor has continued in her role as the nominated Wellbeing Champion, leading the local support model based on the principles of Psychological First Aid (i.e. Care, Protect, Comfort, Support, Provide, Connect, Educate). This workstream is aligned to the Healthy Working Lives Group whose workplan provides a calendar of activities and promotional campaigns that incorporates many of the wellbeing initiatives for the year ahead.

The Wellbeing Champion continues to attend the Scottish Government Champions Network, ensuring awareness of national initiatives and promoting these within TSH. This includes the National Wellbeing Hub and Focus on Wellbeing Webinar Programme. The Champions Network May Newsletter featured a story about the TSH week of gratitude which took place in February 2021.

Staff continue to use the Wellbeing Centre on site daily as a drop in facility to take a tea break or a lunch break or to use the massage equipment. As staff begin to return to the workplace and restrictions ease, it is hoped to have more face to face activities that staff can engage in within the centre at lunch times and ward handover times. Managers are being asked to include a visit to the Wellbeing Centre as part of the Induction programme for new employees and student placements. Additional staff resourcing has been agreed to support this service, as well as pastoral support through NHS Lanarkshire. There is also great support for this initiative throughout the organisation with staff spontaneously providing home baking to be shared with colleagues as a goodwill gesture and as a means of connecting.

The HR and Wellbeing Group provides regular focus through which Heads of Departments and line managers are reminded of the benefits of the Wellbeing Centre, as well as to encourage staff to make best use of the facility.

Planning is underway to develop the Family Centre garden area to offer a space for staff to use. This area will be split in two offering a garden for patient visitors and a separate section for staff. Until the tendering process and works are completed, it has been proposed to utilise the existing garden and introduce some temporary garden furniture which is being moved from the central grounds area.

The Staff Wellbeing Centre registered with The Work Perk to receive free sampling of products that are suitable to pass on to TSH staff. To date, the service has organised coffee shots, mini chocolate bars and household cleaning products.

In April, staff from across the hospital signed up to take part in a reading group focusing on the book ‘Dare to Lead’ by popular author Brene Brown. Meetings were led virtually through MS Teams by the Wellbeing Champion. This was a popular workstream with 25 staff from different disciplines signing up to the programme. Groups met weekly and explored the book, with an aim to reach a shared understanding of what courageous leadership looks like within The State Hospital and how to build specific courage skills.

As part of the *What Matters To You?* Initiative on 9 June, staff across the hospital were encouraged to take time, as part of their team, to reflect on the Covid-19 experience and the ways in which this this has impacted each member of the team personally and professionally.

The second 'How Are You' staff wellbeing survey was launched on 29 March and ran until 10 May. Results of this survey are now being analysed and expected to be reported by the end of June.

3.9.5 Personal Development Planning and Review (PDPR) compliance

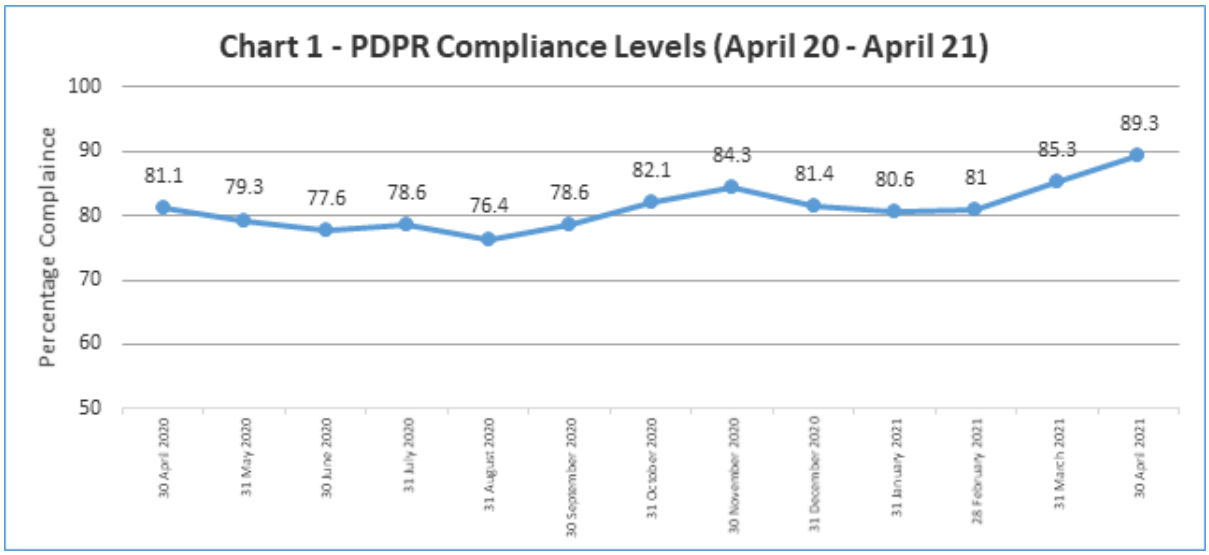
In line with national targets, a key priority within the State Hospital's Staff Governance Action Plan is to ensure that all staff have an annual KSF personal development planning and review meeting with their line manager.

As at 30 April 2021:

- The **total number of current (i.e. live) reviews was 545 (89.3%)**.
- A total of 50 staff (8.2%) had an out-of-date PDPR (i.e. the annual review meeting is overdue).

- A further 15 staff (2.5%) had not had a PDPR meeting. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

Chart 1 shows the trend in organisational PDPR compliance levels for the 12-month period from April 2020 to April 2021.



As is evident in the chart above, there has been an incremental improvement in overall compliance since January 2021. This is likely to be due in part to a reduction in staff absence levels and the gradual lessening of the impact of the COVID-19 pandemic and associated resumption of previous work routines and practices.

3.10 Communication

Staff Bulletins continue to provide key communication throughout the organisation, providing high level feedback to staff about national developments, as well as more focussed updates for TSH.

Information is captured within weekly staff bulletins, which has a specific section dedicated to updates in relation to Covid-19, and dedicated bulletins are produced when needed. The recent

changes in the management structure were promoted through a dedicated bulletin, as well as through directorate team meetings.

3.11 Digital Technology

As the Board is aware, this is a key area of focus in 2021 and has been essential in the response to the pandemic. The eHealth department has been focusing on several projects at present that will bring benefits to both staff and patients. Additional staff have now been recruited to two-year term posts split between eHealth infrastructure as well as medical records.

In terms of equipment availability, global supplies continue to be problematic - all NHS Boards are experiencing worldwide supply deficiencies and increasing costs.

Within TSH, the Board is asked to note that work has commenced on preparation for the upgrade of the electronic patient record system (Rio) and that the rollout of Windows 10 across the whole organisation is expected to be completed by September 2021. TSH has set up an Office 365 project Group which ensures that TSH is fully linked in and prepared for the continuing rollout of Office 365 nationally.

4 RECOMMENDATION

The Board is invited to:

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

2. To consider and outline any additional reporting requirements that the Board may require in this area.

Author:
Margaret Smith
Board Secretary
01555 842012

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support operational management and governance structure of the NHS Board during Covid 1-19 emergency response ensuring the NHS Board received detailed reporting across directorate areas.
Workforce Implications	Considered in this report – noting staff wellbeing, staff appraisal arrangements and recruitment.
Financial Implications	Financial implications outlined within a separate dedicated Financial report related to Covid-19 presented at same Board meeting
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested for each meeting
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Fully outlined and considered in the report: staff patients, carers, volunteers
Equality Impact Assessment	Not required for this report as monitoring summary report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Item:	Item No. 7b
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Financial Governance – Covid-19
Purpose of Report:	For Noting - Update on current Covid financial impact

1 SITUATION

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

2 BACKGROUND

These specific Covid-related costs have been formally reported on a regular basis, since March, to the Scottish Government's Covid-19 Health Finance team within the Health Finance and Infrastructure Directorate. Feedback / discussion has followed directly on each of these reports, including a focus on consistency of reporting between boards.

An initial report – for the three-month period April-June (Q1) – was submitted mid-August, incorporating a forecast of expected costs for the remainder of the financial year.

The principal SG exercise for funding purposes was to collate the Q1 reports for all boards, with a review to assess the overall NHSScotland position and what proportion of individual board costs were to be reimbursed as additional in-year allocation. The outcome of this review was notified on 1 October, as noted below in 3.1 and 3.2.

The next stage of SG review related to the report for the Q2 period (to 30 September) – which was submitted in late October. From this next review, updated allocations were issued in January 2021 to those boards for whom there had been additional Covid costs unidentified or underestimated at the initial stage. From this – in line with our requirements – there was no additional Covid funding necessary to TSH.

Further to Q3 cost submissions in January 2021, during February there was further consultation between SG and individual boards to look at expectations for Covid costs in the final quarter, from which it was anticipated that where actual costs materialised below forecast then there would be an element of handback. For TSH – per 3.2.1 – this relates principally to staff costs and contingent project costs.

We have now met with SG to review the Q3 and Q4 position and the outcome is noted below in 3.1.1.

3 ASSESSMENT

3.1.1 Financial Governance and SG allocation 2020/21

As previously notified, any specific individual costs in excess of £100k with relation to Covid19 were 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.

For the returns submitted, including forecast costs for the remainder of the year, the revenue costs as noted in paragraph 3.2 below were specified in the Hospital's Covid19 returns – including contingent items.

While initial indications from SG were that all Boards' estimated Covid-related costs would be reimbursed in full, it became clear during Q2 that this would not be affordable for SG, and the actual position now confirmed as an additional allocation was that TSH would receive approx. £1.6m for 2020/21.

As noted above, we have now met with SG to review the outturn and the position was that the Hospital Covid allocation was not fully utilised, principally due to –
i – sickness levels and resultant overtime not reaching the highest potential levels;
ii – some dual running post costs not materialising in the forecast timeframe;
iii – perimeter project contingency costs not being at the highest risk levels forecast.

However, this being a position shared with many other boards, after some consideration it was instructed by SG that – rather than this being adjusted (approx. £300k) within our Covid allocation and then a further allocation issued for new payroll funding requirements – we offset this against additional costs materialising in late 2020/21 with regard to the £500 staff bonus now paid, and the 1% pay increase announced to apply retrospectively from December 2020. This was done as agreed and the breakdown notified to SG for their collective reporting.

3.1.2 SG allocation 2021/22

While it was initially anticipated that Covid costs for 2021/22 would be reported to SG for allocation agreement in the same was as Q3 and Q4 of 2020/21, it has now been indicated that this will not be the process. Instead, we will continue to report Covid costs through Q1 and into Q2, with the timing of the review for alllocations then to be determined likely to be summer 2021, in a similar way to that which was applied in August 2021 for the early months of the Covis crisis.

While our budget for 2021/22 is drafted with an assumption that Covid-related costs will continue though Q1 and Q2 only, we will monitor this position on a month-by-month basis for reporting and forecasting to ensure all relevant costs are included for consideration in the new year's Covid allocation process.

3.2.1 Covid19 specific costs

The principal revenue costs incurred in relation to Covid19 in 2020/21, as submitted in the Board's Q3 return and Q4 forecast (Q4 return pending after year-end) are as undernoted.

i. Overtime costs £1.2m – additional overtime incurred each month due principally to the increased levels of staff absence arising from Covid absences (classified as special leave), together with an element of high level clinical demands.

ii. Nursing recruitment Q1-2 £260k – being an additional 12 student nurses on 6-month contracts. While this was initially understood to be funded by NES as part of a national initiative to support Covid pressures, this did not materialise and it was then to be regarded as provided directly through the Covid funding.

iii. Additional deep cleaning £10k – being extra cleaning requirements specific to rooms for patients with positive Covid test results.

iv. Telephony, related IT and digital costs £60k – being the costs of teleconferencing and other remote communication costs now being incurred.

v. Estates/facilities costs £22k – including the requirement for additional lockers, trolleys, chairs etc.

vi. "dual running" staff costs – £260k.

We have incurred the costs of the Covid-19 support team – having in March established a specific team to provide support to the management of the Covid-19 crisis, comprising 9 members of staff seconded from various departments where their normal workload either stalled or was being undertaken by others in the team, with no backfill in place. Being staff seconded in this manner, these costs are viewed as supported from within budget.

However, the Hospital has now taken forward new staffing posts which are resulting from the ongoing crisis and the recommencing of areas of work while – at the same time – maintaining this Covid support team – the "dual running" costs of these posts is now recognised. With the timing of posts being advertised, and some being able to addressed by revised approaches and vacancy management, the level of dual running costs did not materialise at the forecast level.

vii. IT costs £40k – additional equipment (laptops, mobile phones, licences etc.) necessary in order to facilitate remote working for a number of staff and other essential IT site requirements.

viii. Other equipment costs £14k – including new monitors, some pandemic PPE stock, uniforms, and patient tvs/radios.

ix. Perimeter project contingent costs Q4 £250k – this was included in our costs to cover the contingent risk of any project delay or contractor access delay arising from staff being unable to access TSH site due to Covid – cost estimate being based on potential daily delay costs which could arise. While an element of delay was incurred due to the site restrictions in late January / early February, the final value is under evaluation for final agreement as the actual cost, while relating to this period, will be charged in 2021/22.

3.2.2 Covid19 costs – vaccinations programme 2021

In addition to the above, there are costs to the Hospital which arose from taking forward the programme of Covid-19 vaccinations for frontline staff in Q4 2020/21.

These costs (relating to staffing – vaccinators and backfilling of roles, refrigeration / storage of vaccines etc.) amounting to £30k were submitted to SG as part of an additional national reporting schedule. With the vaccinations still ongoing in territorial boards, and the second stage timing underway, these costs will be subject to separate collation for review by SG and future consideration for any reimbursement.

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 financial implications – for information only
Route to SG/Board/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Finance and 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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Reference:	Item No: 8
Author:	Clinical Governance Committee Chair
Title of Report:	Clinical Governance Committee - Annual Report 2020/21
Purpose of Report:	For approval

1 Situation

The attached Clinical Governance Committee Annual Report outlines the wide range of activity overseen by the Committee during 2020/21. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 Background

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

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

3 Assessment

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

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

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

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

4 Recommendation

The Board is asked to approve the Governance Reporting Arrangements, Terms of Reference, Programme of Work and the Clinical Governance Committee Annual Report.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT

1 April 2020 – 31 March 2021

1. Introduction

The State Hospital, like all NHS organisations, has a statutory responsibility to establish clinical governance arrangements to ensure continuous improvement in the quality of care and treatment provided to patients. The national requirements for clinical quality have been the subject of substantial guidance, from the *Clinical Governance and Risk Management Standards* published by NHS Quality Improvement Scotland (NHS QIS) in 2005, to *Better Health, Better Care*, published by NHS Scotland in 2007, the Scottish Government's publication of the *Healthcare Improvement Strategy for NHS Scotland* in 2010 and subsequently through the NHS Healthcare Improvement Scotland *Making Care Better – Better Quality Health and Social Care for Everyone in Scotland 2017-2022.* The 5 main strategic priorities are:

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

The underlying principle of effective clinical governance is that systems and processes provide the framework for patients to receive the best possible care. This report provides an overview of the work of the Clinical Governance Committee during 2020/21 and examples of good practice and matters of concern.

2. Committee Chair, Committee Members and Attendees

Committee Chair
Nicholas Johnston, Non-Executive Director (up to 31 December 2020)
Cathy Fallon, Non-Executive Director (from 15 January 2021)

Committee Members
Brian Moore, Non-Executive Director
Stuart Currie, Non-Executive Director (from 4 February 2021)
David McConnell, Non-Executive Director (up to 31 December 2020)

Attendees
Terry Currie, NHS Board Chair (up to 31 December 2020)
David McConnell, Non-Executive Director Interim NHS Board Chair (from 1 January 2021)
Gary Jenkins, Chief Executive
Prof. Lindsay Thomson, Medical Director
John Marshall, Head of Psychological Services
Mark Richards, Director of Nursing, AHPs and Operations
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
Margaret Smith, Board Secretary

The committee can decide to invite the Board Chair to sit as a member of the committee, for a meeting, should this be required for quorate decision-making.

3. Meetings during 2020/21

During 2020/21 the Clinical Governance Committee met on 4 occasions, in line with its terms of reference. Meetings were held on:

- 14 May 2020
- 13 August 2020
- 12 November 2020
- 11 February 2021

4. Reports Considered by the Committee During the Year

During 2020 the headings used within the reports were changed to make the reports more quality focussed. The new headings are:

- Core Purpose of Service/Committee
- Current Resource Commitment
- Summary of Core Activity for the last 12 months
- Comparison with Last Year's Planned QA/QI Activity
- Performance against Key Performance Indicators
- Quality Assurance Activity
- Quality Improvement Activity
- Stakeholder Experience
- Planned Quality Assurance/Quality Improvement for the next year
- Next review date

References – *this should be any references being made to national documents within the report*

Appendices - *for Committees an appendix must be added at the back highlighting the following:*

- Governance arrangements for Committee
- Committee membership
- Role of the committee
- Aims and objectives
- Meeting frequency and dates met
- Strategy and workplan
- Management arrangements

4.1 12 Monthly Internal Governance Reports

Fitness to Practice
The Committee received a report in relation to Fitness to Practise at its May 2020 meeting. The reporting period covered was 1 April 2019 - 31 March 2020. 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 noted that during 2019/20, two employee NMC registrations lapsed, although both staff members are now re-registered. The Committee noted the report and agreed that it should also be flagged to the Staff Governance Committee.

Infection Control
Due to the pressures of Covid-19 on the Infection Control member of staff the 12 monthly report was submitted to the August 2020 meeting rather than the scheduled May 2020 meeting. The Committee noted the progress in the Infection Control Annual Report 2019/20 (covering 1 April 2019 - 31 March 2020) and endorsed the Programme of Work for 2020/21. The report outlined the wide range of Infection Control activity undertaken within the Hospital and summarised the work conducted by Infection Control Services. Although there was a key achievement noted for the increase in uptake of the flu vaccination for both staff and patients, there were also areas of concern noted: the number of Hand Hygiene audits submitted across

the site; the increased number of DATIX submitted for the non-compliance with the Safe Management of Linen policy; and the lack of compliance with mandatory training.

Although not identified throughout the review period 2019/2020, the report identified that through the Covid-19 Pandemic it was realised that having a single Infection Control Nurse poses a lack of resilience in this is area. It was agreed that recruitment and education to the Infection Control Department should be a future service development.

Research Committee/Research Governance and Funding

In May 2020 the Committee received and approved the 2019/20 Research Committee Annual Report. The reporting period covered was 1 April 2019 - 31 March 2020. The report highlighted the governance arrangements in place along with a range of areas of good work within the State Hospital and Forensic Network. The Committee were informed that discussions had taken place to look at studies on staff wellbeing given the significant impact the Covid-19 pandemic has had, trying to evaluate impact and assessment for planning and future planning should anything similar arise. It was agreed that this would be factored in to the strategy which is due for renewal this year.

Duty of Candour

The second annual report for Duty of Candour was tabled at the August 2020 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 2019 and 31 March 2020 the Risk Management Department forwarded 43 incidents to the Duty of Candour Group, one of which met the duty of candour criteria and was reviewed as a duty of candour incident. This resulted in an apology issued to the patient; learning from this incident has been noted and is being taken forward by Nursing Practice Development. The Duty of Candour group continued to meet monthly and reviewed any incidents on a weekly basis.

Patient Safety

In August 2020 the Committee received and approved the Patient Safety Report covering the period 1 July 2019 - 30 June 2020. The 4 principles remained: Communication; Leadership and Culture; Least Restrictive Practice and Physical Health. Key pieces of work included: the introduction of patient support plans into wards; a new as required medication monitoring form introduced into RiO; leadership walkrounds took place with involvement from members of the committee (up until January 2020); a focus on medication safety; monitoring of incidents of restraint and the clinical pause was successfully embedded across the hospital. The national reporting was paused in March 2020 due to the Covid-19 pandemic. No date for this resuming had been received by the August 2020 meeting.

Forensic Network Medium and High Secure Care Review Visit – Action Plan

At the August 2020 and February 2021 meetings the updated actions from the Forensic Network Peer Review Visit were tabled for information. By February 2021 there were 4 actions outstanding from the original 37. Work has commenced to close off the last remaining actions. Only one high graded action was outstanding and this was due to the hospital being unable to transfer patients between hubs due to current national pandemic restrictions until August 2020.

Medicines Committee

Due to the pressures of Covid-19 on the Pharmacy Department the 12 monthly report was submitted to the August 2020 meeting rather than the scheduled May 2020 meeting. The Committee received and noted information on the key pieces of work undertaken throughout the period 1 July 2019 - 30 June 2020 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; maintaining supply processes to the wards during Covid-19 challenges and preparing stocks for possible respiratory and end of life care;

ensuring all patients have a regular review of their mental health and physical health medicines; continuous review of national medicine supply alerts and shortages; monitoring of expenditure; collaboration with NHS Lothian for future electronic prescribing and proactive work around medication incidents with better follow up and learning due to the Medication Incident Review Group and Nursing Practice Development raising awareness around outcomes of incidents.

Corporate Risk Register
At the August 2020 meeting, members received and noted the Corporate Risk Register. The Committee asked that future reports only contain the risks where the Clinical Governance Committee could add value, rather than receiving the whole register.

CPA/MAPPA
At the November 2020 meeting the Committee noted the report covering the period 1 October 2019 - 30 September 2020 and supported the future areas of work. For the second consecutive year, 100% of transfers were managed through the CPA process during the reporting period. The report identified a number of key areas in relation to Multi-Disciplinary CPA attendance, Patient and Carer Involvement and Strategic Engagement and Representation. 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 a specific MAPPA policy and DPIA for The State Hospital to be developed and adopted.

Child and Adult Protection
The Committee received and noted the report in November 2020 that covered the period 1 October 2019 - 30 September 2020. 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 2020 the Committee received and noted the 12 month rolling report from the Physical Health Steering Group covering the period 1 October 2019 - 30 September 2020. 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: continue to develop, support and monitor the supporting healthy choices agenda; look at Physical Health data pre and post Covid and ways that we can use this data to establish a “new normal”; continue to monitor patient’s physical activity and review what effect the “re-opening and new normal” will have on patient’s physical activity levels and supporting key dietary messages, to promote good nutritional care and healthy eating within the restrictions of a current pandemic. A priority was also noted to be the recruitment of a Practice Nurse due to the current vacancy and upcoming retirements.

Rehabilitation Therapies Service
In November 2020 the Committee approved the report covering the period 1 October 2019 - 30 September 2020 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 improvements in percentage of reviews attend by Occupational Therapists and Dietitians; an increase in

reports available by Occupational Therapists; improvement on the function occupational therapy brings using the AMPS standardised assessment. Future areas of work for the service included: to implement a Recovery Through Activity manualised group intervention; increase employability opportunities – review employability pathway to maximise opportunities throughout the hospital; **i**ncrease number of staff throughout the hospital trained in talking mats to aid communication; explore further interpretation of collected data, review need for assessment database and reduce any repetition in data; increase capacity in delivering service improvement and leadership development; explore opportunities for digital interventions; join national work streams on rehabilitation and recovery framework; review Art Therapy and Speech and Language Therapy provision. The Committee commended the flexibility of AHP staff during the pandemic to support patients to access activities.

Clinical Governance Group
At the February 2021 meeting the Committee received and noted the 12 monthly report from the Clinical Governance Group covering the period 1 January - 31 December 2020. 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: MCCB/Copyright issues; challenges with the completion of PANSS; Skye Activity Centre quarterly reports; trauma informed care; approval of the Clinical Effectiveness Annual Report and the Person Centred Improvement Service 12 monthly report; reports on exceptional circumstances and report on the hospitals response to Covid-19. The areas of future work included: supporting the implementation of the Clinical Model including preparation of guidance on the 4 ward types, patient flow, model fidelity and development of measures to monitor the model; oversee the implementation of the QI Physical Activity Project to ensure activity within the patients' objectives are reflected in the activities delivered to the patient and ongoing focus on quality improvement, realistic medicines and TSH3030 initiative.

Mental Health Practice Steering Group
A report was submitted to the February 2021 meeting covering the period 1 January - 31 December 2020. The key pieces of work from the group included: exploring the grounds access process within the hospital with a view to streamlining this; monitored the advance statements being made by patients; ensured evidence based practice is implemented through gap analysis and policy work and monitored the Psychological Therapies data. Future areas of work will include review and propose changes to the Care Programme Approach process; develop and test ways to increase the utility of clinical outcome measures for frontline staff; support the Realistic Medicine action plan and support the development and implementation of the new Clinical Care Model.

Psychological Therapies
At the February 2021 meeting the Committee noted the Psychological Services report covering the period 1 January - 31 December 2020. The report acknowledged the impact that the pandemic has had on the Service with regards to providing group work to patients. The report was centred on the 6 quality dimensions from The Healthcare Quality Strategy for NHS Scotland. Key service developments during 2020 included: the completion of Risk Awareness training; the implementation of a New Assessment Checklist and supporting the HR and Wellbeing Group in reducing the staff sickness absence across the hospital. Due to the pandemic there were some areas of work that are still in progress. These included: the consideration of low intensity training on psychological trauma for nursing staff; the delivery of Healthy Living Group in each hub; improvements to clinical formulations and the pilot of the new Matrix Consensus Cognitive Test Battery (MCCB).

4.2 Standing Items Considered by the Committee during the Year

Covid-19
In March 2020 restrictions were placed on the hospital in relation to the national outbreak of Covid-19. In response to this a paper was presented at all 4 meetings. The paper gave updates on the number of patient tests that had been required due to symptoms or close

contact with another patient testing positive; the number of patients that had tested positive; the incident command structure; the implementation of an Interim Clinical Support Policy (that had many updates as national restrictions changed); the monitoring that was ongoing through the Operational Model Monitoring Group to ensure that the patient models being used were not having a detrimental effect of the patients mental wellbeing or their access to fresh air or physical activity; national guidance that had been received; updates from the Scientific and Technical Advisory Group (STAG); patient flow; PPE; updates on the staff and patient vaccine programme; along with updates on the communication methods being used for staff and patients to ensure they were being kept up to date with the ever changing landscape of restrictions.

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

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. At the February 2021 meeting, the Committee was also asked to note that as part of the interim management structure established on 9 December 2020, the delivery of the complaints service is now through the Corporate Team with the Board Secretary taking responsibility in this area. The Committee were advised that work is in progress between the Corporate Team and the Person Centred Improvement Team to see how they can bring the Learning from Complaints and Learning from Feedback reports together to provide one report that covers the whole range of patient feedback and complaints

Learning from Feedback
The quarterly Learning from Feedback report was considered and noted at every Clinical Governance Committee meeting. These reports highlight the feedback received, encompassing concerns, comments and suggestions, (including evaluation forms) and any compliments/positive feedback received. The report notes the outcome from all feedback and any lessons that have been learned by the hospital. The Committee were also given assurance that, during the current pandemic situation, the Patient Centred Improvement Team are still very focussed on reaching out to wards and ensuring patient and carer voices are heard irrespective of the situation we are in. Examples of this included: various mechanisms were used for engagement, such as the use of the graffiti wall; positive feedback received around regular access to fresh air through walks 7 days per week; changes to meal delivery with meals being plated and delivered to patient rooms, and themed meals being positively received.

Patient Movement Statistical Information
The Committee received and noted 2 reports during the year at its May 2020 and November 2020 meetings. The May 2020 report covered the reporting period 1 October 2019 - 31 March 2020 and the November 2020 report covered 1 April 2020 - 30 September 2020. 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 every Clinical Governance Committee 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 all the meetings during 2020/21. The reports included any challenges with staffing through the Covid-19 pandemic; including the number of times a ward had to close due to staff shortages (this would mean patients being cared for in their rooms for the duration of the shift) and the challenges the hospital has recruiting an acceptable gender mix due to the small numbers of males going into mental health nursing.

5. Discussion Items During the Year

Due to the move to the meetings taking place on MS Teams and the additional Covid-19 item being added to the agenda there were no discussion items during 2020/21.

6. Special Topics/Items for Approval

Clinical Governance Annual Stock Take
At its May 2020 meeting, the Committee received and noted: the Clinical Governance Reporting Structures for 2020-21; the Programme of Work for 2020-21 subsequent to any changes that may arise at future meetings; the Clinical Governance Committee Terms of Reference; and the Clinical Governance Annual Report 2019-20. The Annual Report summarised the work of the Committee during the financial year 1 April 2019 - 31 March 2020.

7. Areas of Good Practice Identified by the Committee

- The Committee asked for it to be noted that they were very impressed with the efforts of all staff to help patients and carers cope with the changes during Covid-19.
- Staff flexibility as evidenced from the Rehabilitation Therapy Services 12 monthly report was also noted as a good practice point.
- The CPA/MAPPA 12 monthly report highlighted that 100% of transfers were managed through the CPA process for the 2nd consecutive year.
- The Person Centre Improvement Team were commended for reaching out to wards and ensuring patient and carer voices were heard irrespective of the pandemic situation we were in during 2020.

8. Matters of Concern to the Committee

Matters of concern	Update
Hand hygiene compliance remains a challenge in some areas. A series of face to face meetings between Karen Burnett, Senior Charge Nurses and Lead Nurses has been included in the 2021 programme of work to move responsibility and activity locally around the infection control agenda.	The hospital is currently recruiting an Infection Control Quality Improvement Facilitator who will focus on this area with a view to improvements during 2021.

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.

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 2020/21**.**

Cathy Fallon

CLINICAL GOVERNANCE COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Clinical Governance Committee

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 Chair of the Board, and the Chief Executive, shall both be in attendance.

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.

Should the meeting not be quorate, the Chairperson may be asked to step in as a member, if agreed by the Committee

Members:
- B Moore
- C Fallon (Chair)
- S Currie

In Attendance
- David McConnell, Interim Chair
- Gary Jenkins, Chief Executive
- 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 and Operations
- Robin McNaught, Finance and eHealth Director
- Dr Khuram Khan, Chair, Medical Advisory Committee
- Sheila Smith, Clinical Effectiveness Team Leader
- Margaret Smith, Board Secretary

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. The Board Chair may be invited to sit at as a member of the committee at a meeting to form a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next committee meeting. A Personal Assistant will take the minutes.

The approved minutes of each committee meeting will be submitted to the next meeting of the Board.

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
- To ensure systems are in place to measure and monitor duty of candour and any lessons to be learned
- Complaints are handled in accordance with national guidance and lessons will be learned from their investigation and resolution (including reports of the Scottish Public Services Ombudsman and the Mental Welfare Commission)
- Arrangements are in place to support child and adult protection obligations.

4.4 Health, Wellbeing and Care Experience

- To ensure that the environment supports delivery of high quality care with a culture and appropriate mechanism to allow staff and others to raise concerns on the 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 systems are in place to monitor and measure the mental health and physical health requirements of our patient population, including medicine management, psychological therapies and rehabilitation services.
- To ensure that arrangements are in place to embed Person Centred Improvement activities, including equality and diversity issues pertinent to clinical governance.
- To ensure that care is provided by appropriately trained and skilled professionals with the competencies required to deliver the required care.
- To ensure that clinical policies and procedures are developed, implemented and reviewed.
- To ensure that poor performance of clinical care will be identified and remedial action taken.

4.5 Control Assurance

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

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

5 AUTHORITY

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

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

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

7 REPORTING FORMAT AND FREQUENCY

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

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

8 COMMUNICATION AND LINKS

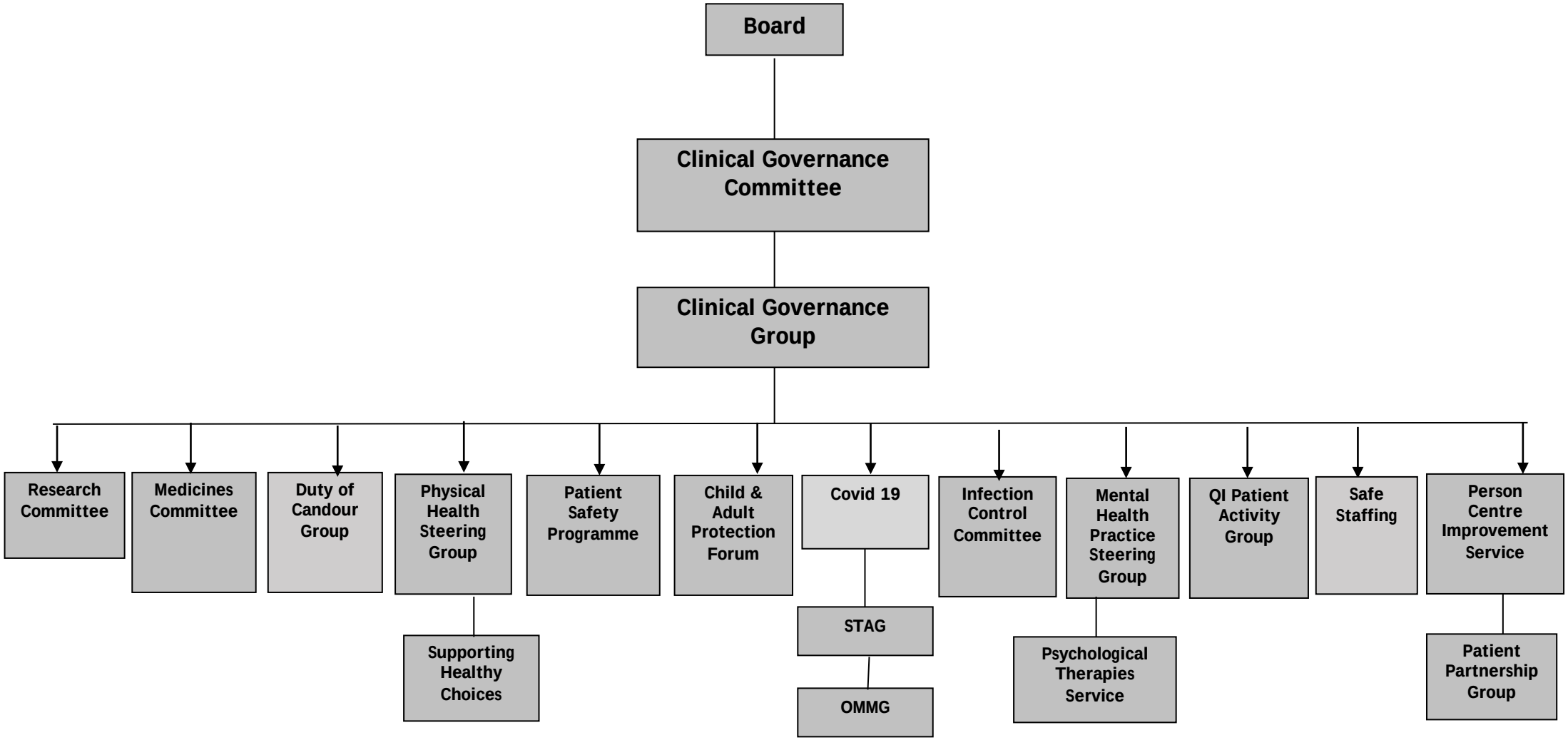
The Chair of the Committee will ensure that relevant issues are shared with the Staff Governance Committee.

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

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

Subject to annual review.
Next revision: May 2022.

ORGANISATIONAL CHART FOR CLINICAL GOVERNANCE



Support for Clinical Governance:
Clinical Effectiveness and Risk Management Departments

Clinical Governance Committee Programme of Work 2021/22

Area of review	11th February 2021	6th May 2021	12th August 2021	11th November 2021	February 2022	May 2022	August 2022	November 2022
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	• Medicines Committee/ Pharmacy • Research Committee / Research Governance and Funding • Fitness to Practice • Patient Movement – Statistical Report • Infection Control • Safe Staffing report • Patient Learning 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	• 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 • Patient Learning 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	Covid 19	Covid 19	Covid 19	Covid 19	Covid 19	Covid 19	Covid 19
Special topics / items for approval (15 minutes)		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)	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA

Paper No. 21/41

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Reference:	Item No: 9
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
Purpose of Report:	For Noting

1 SITUATION

This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in April 2021. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational learning and development. It contributes to the strategic intention of The State Hospital to embed quality assurance and improvement as part of how care and services are planned and delivered

2 BACKGROUND

Quality Assurance and Improvement in The State Hospital links to the Clinical Quality Strategy 2017 – 2020. The State Hospital 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

The paper outlines key areas of activity in relation to:

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

4 RECOMMENDATION

The Board are asked to note the content of this paper

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Quality Improvement and Assurance report supports the Quality Strategy and Corporate Objectives by outlining the actions taken across the hospital to support QI and QA
Workforce Implications	Workforce implications in relation to further training that may be required for staff where policies are not being adhered to.
Financial Implications	Covid monies have been approved to continue with the Daily Indicator Report due to CED staff workload/ weekend working
Route To Board	Route to the Board is via the CMT
Risk Assessment (Outline any significant risks and associated mitigation)	The main risk to the organisation is where audits show clinicians are not following evidence based practice.
Assessment of Impact on Stakeholder Experience	It is hoped that the positive outcomes with the weekly indicator report will have a positive impact on stakeholder experience as they will be getting more fresh air, physical activity and timetable sessions
Equality Impact Assessment	All the policies that are audited and included within the quality assurance section have been equality impact assessed. All larger QI projects are also equality impact assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	This will be part of the project team work for any of the QI projects within the report
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications.

	□ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

QUALITY ASSURANCE AND IMPROVEMENT IN THE STATE HOSPITAL

JUNE 2021

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:

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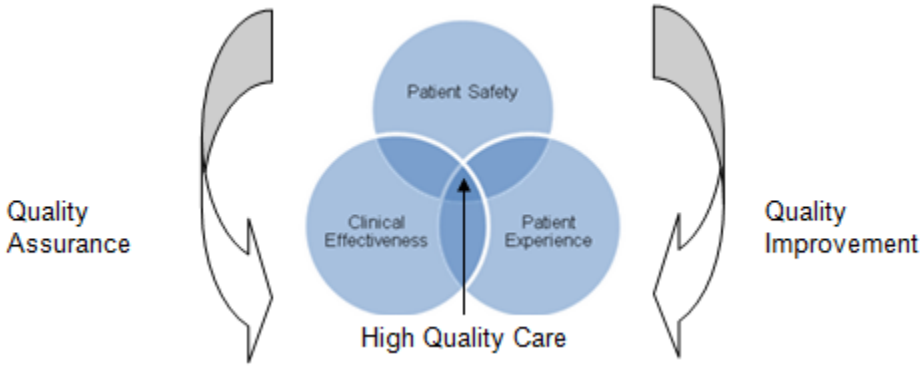
- Evaluating and disseminating our results;
- Building improvement knowledge, skills and capacity.

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.



ASSURANCE OF QUALITY

Clinical Audit

The Clinical Effectiveness Team carry out a range of planned audits. Over the course of a year there are usually 25 – 28 audits carried out. These aim to provide feedback and assurance to a range of stakeholders that clinical policies are being adhered to. All clinical audit reports contain recommendations to ensure continuous quality improvement and action plans are discussed at the commissioning group.

The Audits that have been completed since the last Board Meeting in April are:

- Observation Policy Sub Heading Audit
- Record Keeping Audit
- Post Physical Intervention Audit
- CPA Spot Check Audit
- Medicine Fridge Audit
- Medication Trolley Audit
- POMH Use of Clozapine Audit

Findings and actions from these included:

Observation Policy Sub Heading Audit

- Medical must improve their use of the observation review note type on RiO. This has been highlighted to medical staff.
- Nursing must improve their use of the observation review note type on RiO. This has been highlighted and will be taken forward through Practice Development
- Consideration to be given to the use of note types to be included in all medical and nursing staff induction programmes. This has been highlighted to Medical and Practice Development.
- Posters have been distributed to all wards to all wards to highlight the areas in need of improvement

Record Keeping

- One patient was not seen by an RMO in March 2021. This is an improvement from 6 in the last audit

Post Physical Intervention Audit

- The information on the Post Physical Intervention Assessment Form and Datix should always correspond.
- For all incidents where the patient is taken to the floor, physical observations should be recorded (with a minimum of consciousness level being recorded if the patient is too highly aroused to take BP/pulse/respirations/ temperature) using the NEWS – changes will be made to the Datix form and RiO to make this clear to staff when they are completing the form.
- Posters have been distributed to all wards to all wards to highlight the areas in need of improvement.

CPA spot check – this audit only looked at the areas for improvement found in previous audit

- Improvements were seen in 6 out of 12 high graded categories and 1 out of 2 medium graded categories
- The actions from the spot check will be monitored through the Clinical Governance Group

Medicine Fridge Audit

- Excellent compliance, with the exception of one ward that was using the wrong recording sheet

Medication Trolley Audit

- Very good compliance and significant improvements from when the audit was commissioned following a Critical Incident Review when the medications were in the wrong dose order and a patient was give the highest dose instead of the lowest dose.

POMH Clozapine Audit (national benchmarking)

- Very good uptake from across the Forensic Network
- Awaiting publication of the report

Audits currently underway, or due to commence include IM Haloperidol, PRN Medication, Lithium Monitoring and Physical Equipment.

Clinical Governance Committee

At the meeting on 6th May 2021 the following papers were presented with a number of quality assurance and improvement activities contained within them:

- Covid 19 Update
- Medicines Committee Report
- Infection Control Annual Report
- Research Committee Annual Report
- Fitness to Practice Annual Report
- Patient Learning Annual Report
- Patient Movement Report
- Safe Staffing Report
- Clinical Governance Annual Report and Stocktake
- Learning from Feedback Quarterly Report
- Learning from Complaints Quarterly Report
- Incident and Patient Restrictions Quarterly Report

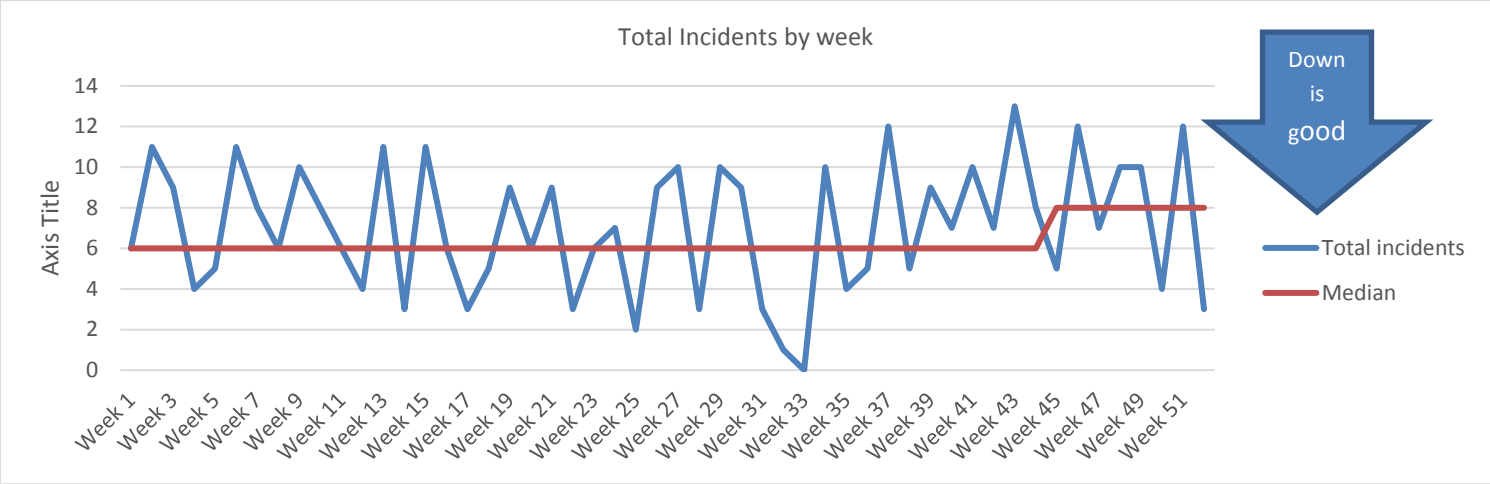
Areas of Good Practice were noted and will be contained within the Clinical Governance Committee Annual Report.

Daily and Weekly Indicator Reports

Clinical Effectiveness continue to collate and present the data that gives the Corporate Management Team the assurance that it is safe to continue with the Interim Operational Policy. A sample of the annual data is below. The full report can be provided on request:

Datix assaults, attempted assaults and behaviour

As can be seen in the graph below, there was random variation at the start of the year, but a shift was seen in the data in week 45 due to the number of consecutive weeks the incidents were above the median. This moved the median from 6 to 8. Since the median was moved, we have continued to see random variation. The increase in the number of incidents in the latter part of the year was down to behaviour incidents rather than attempted assaults or assaults. The increase came under version 17 of the Interim Clinical and Support Services Operational Policy (08/01/2021) where the ward was split into 2 separate households.

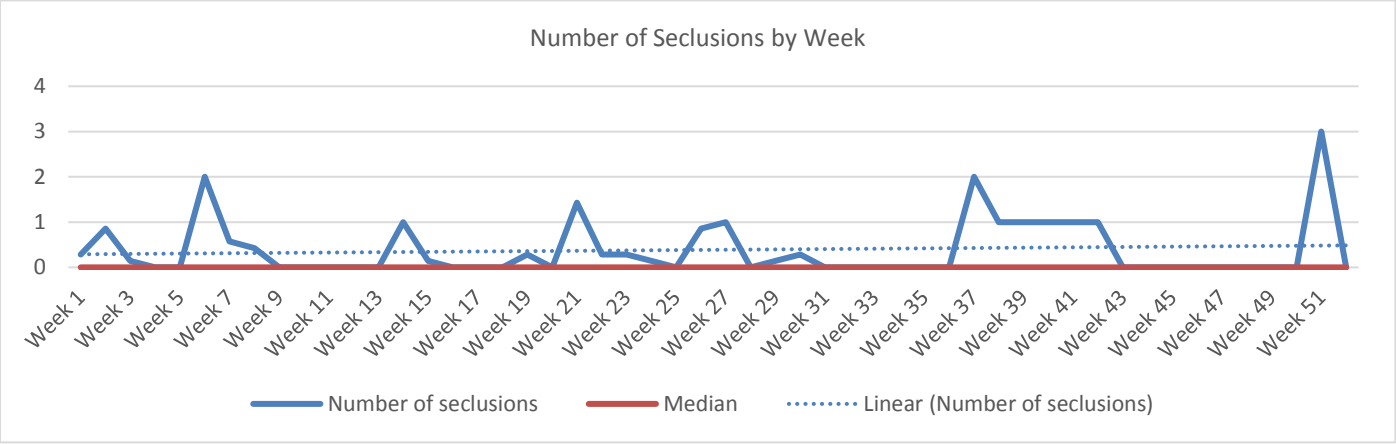


Seclusions

As can be seen below, although there was an increase in the number of seclusions from 21 in 2019/20 to 23 in 2020/21, the number of patients were fewer with 13 in 2019/20 to 9 in 2020/21. The highest number of seclusions per patient in 2019/20 was 5, whereas the highest number in 2020/21 was 7. This was a patient admitted in May 2020. The average number of seclusions per patient also increased between the 2 years from 1.5 to 2.5.

	2019-20	**2020-21**
Number of seclusions	21	23
Number of patients secluded	13	9
Average seclusions per patient	1.5	2.5
Total hours patients spent in seclusion	1915	1251

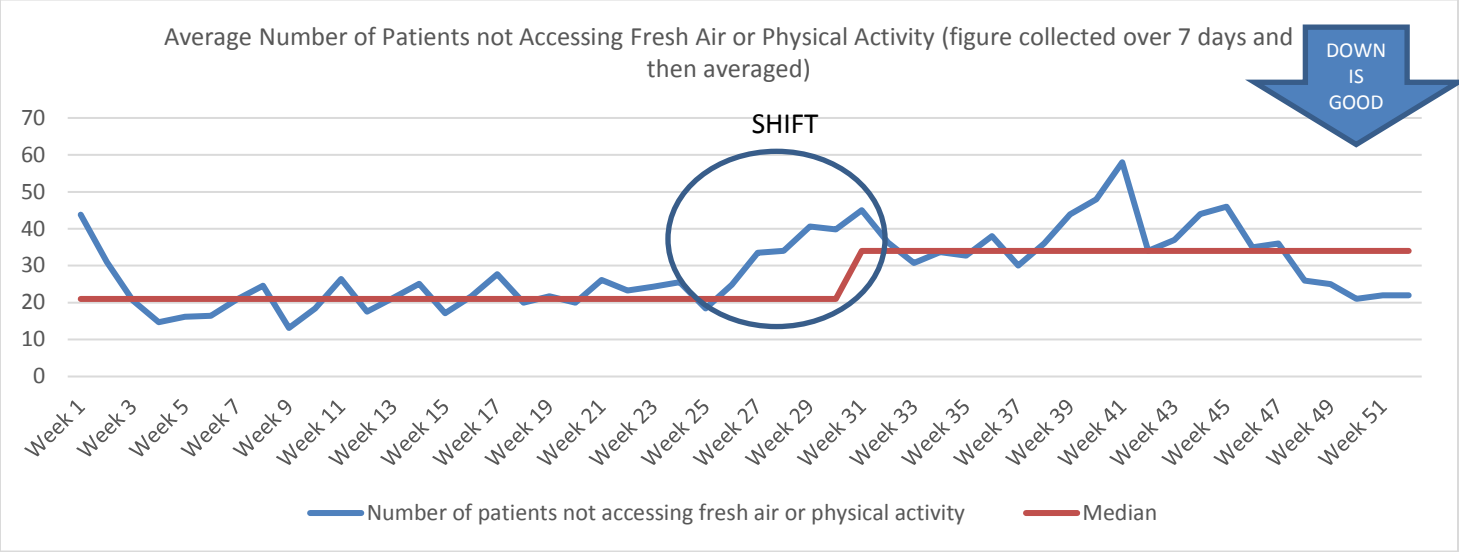
The trend graph shows the overall upward trend in seclusions over 2020/21.



Patient not accessing Fresh air or Physical Activity (this is an average daily figure)

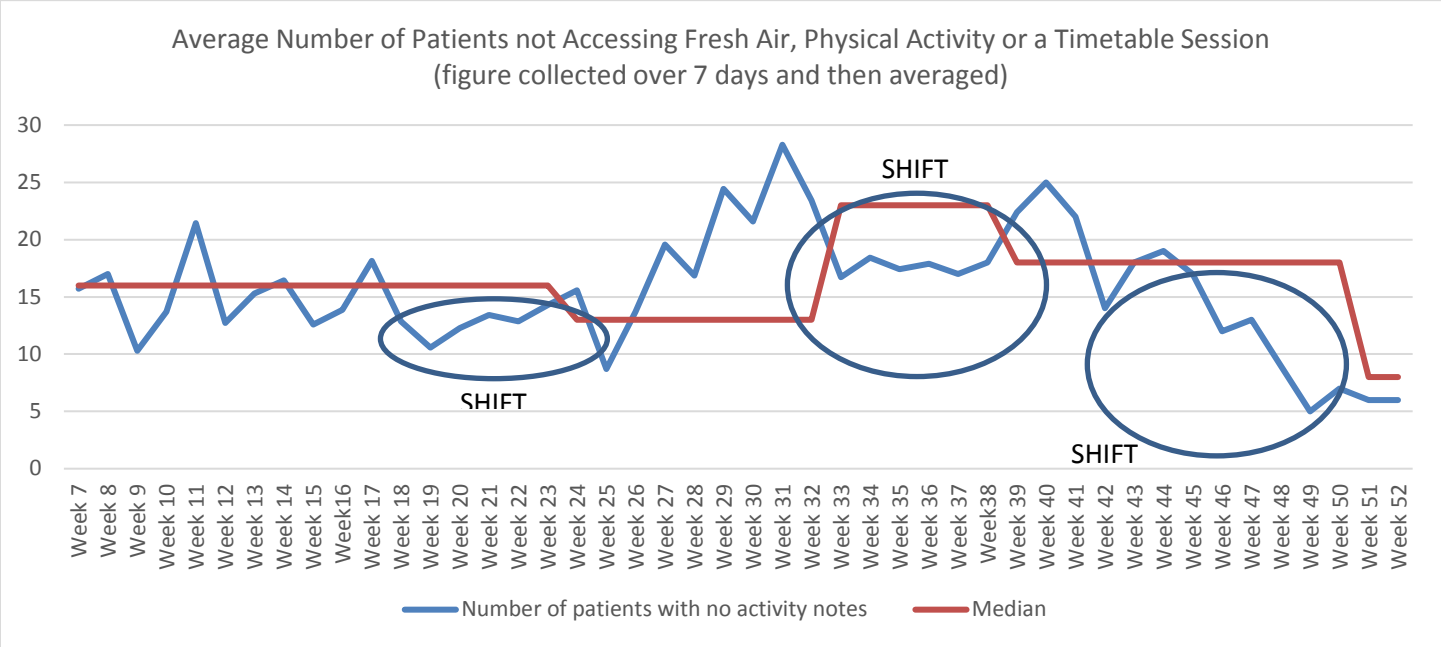
This indicator looks at both the fresh air data from PMTS and timetables and the physical activity data from RiO and highlights the patients that have had no fresh air or physical activity. There is no comparison data for this indicator as the data was only reported in this way in response to Covid-19 and the restrictions through the Interim Clinical and Support Services Operational Policy.

As can be seen there was only one negative shift in the data for patients not accessing fresh air or physical activity. This shift ties in with the shift we saw in both the fresh air chart and the physical activity chart between weeks 25 and 32 (15th Sept and 2nd November) when we had rain for most of the day on at least 7 days and grounds access was restricted to the central area only and escorted grounds access only on a number of occasions. Although outwith the range of this report we saw a positive shift in week 53 (2nd Apr) which ties in with better weather arriving and the start of the Striders Project.



Patients not engaging with fresh air, physical activity or timetable sessions (this is an average daily figure)

One of the main purposes of collecting the daily indicator data was to ensure that there were limited patients that were not engaging with some form of activity i.e. fresh air, physical activity or a timetable session on a daily basis. From week 7, 12th May we started to monitor this. As can be seen, during the year we had 3 positive shifts and one negative shift. The first positive shift came between weeks 17 and 23 (21st July and 7th September); the second between weeks 32 and 38 (3rd November and 21st December) and the third between weeks 43 and 50 (19th January and 18th March). The one negative shift came between weeks 26 and 32 (22nd September and 9th November). These dates again tie in with the very wet weather that we experienced at this time.


Average Number of Patients not Accessing Fresh Air, Physical Activity or a Timetable Session
(figure collected over 7 days and then averaged)
30
25
20
15
10
5
0
SHIFT
SHIFT
SHIFT
Week 7
Week 8
Week 9
Week 10
Week 11
Week 12
Week 13
Week 14
Week 15
Week16
Week 17
Week 18
Week 19
Week 20
Week 21
Week 22
Week 23
Week 24
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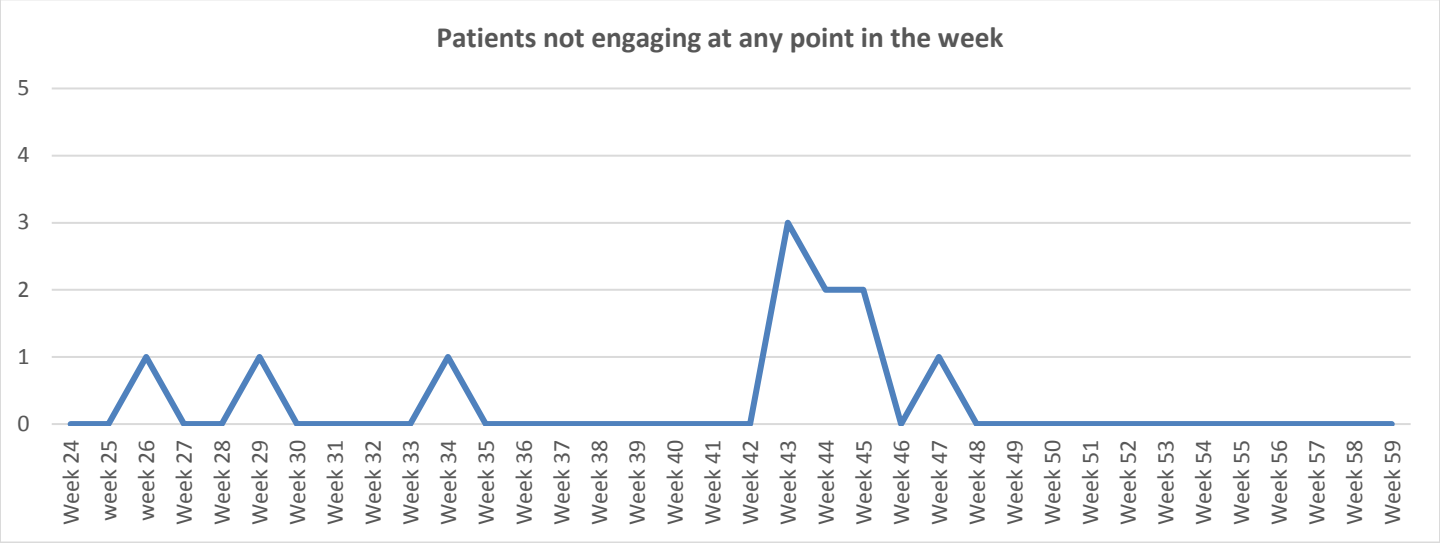
Week 30
Week 31
Week 32
Week 33
Week 34
Week 35
Week 36
Week 37
Week38
Week 39
Week 40
Week 41
Week 42
Week 43
Week 44
Week 45
Week 46
Week 47
Week 48
Week 49
Week 50
Week 51
Week 52
Number of patients with no activity notes
Median

Patient not engaging with fresh air, physical activity or a timetable session at any point in the week
Since week 48 all patients in the hospital have accessed fresh air, physical activity or a timetable session at some point in the week.



QUALITY IMPROVEMENT

Quality Forum

The Quality Forum meets regularly to champion and lead the quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. The QI Forum has supported staff engagement activities through the Covid 19 pandemic with a view to building in quality improvement approaches and methods to recovery and renewal planning. The Quality Forum are currently developing a database of all QI projects across the hospital to enable support and connection as these progress. Notable projects that are currently in development are the QI project on Patent Activity and Improving Observation Practice.

The Quality Forum continues to support and embed QI approaches to innovation and learning using the model for improvement as a guiding approach. Communication and awareness raising are significant areas of activity for the Quality Forum with recent QI update information being shared across TSH.

Quality Improvement Capacity Building

Developing capacity and capability for individuals and teams across TSH has been a focus of activity for the Quality Forum. National training is available through NHS Education for Scotland (NES), specifically the Scottish Improvement Leaders Programme (ScIL) and Scottish Coaching and Leading for Improvement (SCLIP) training which are particularly useful within TSH. The Quality Forum has engage with these national programmes and support TSH applicants as they progress through the development opportunities.

Scottish Coaching and Leading for Improvement (SCLIP) training recruited to three cohorts in 2020, seven TSH staff were successful with their applications and have completed the programme. From these, six are Senior Charge Nurses and 1 Practice Education Facilitator. The Quality Forum are linking in with these staff and supporting spread and sharing of learning from projects. Recruitment for SCLIP cohorts in 2021/22 is currently underway. The focus of these cohorts is Excellence in Care and TSH staff are being supported to submit applications

The Scottish Improvement Leaders Programme (ScIL) programme has commenced following a delay due to Covid 19. TSH has 3 staff working thorugh this programme, again the Quality Forum are connecting with participants as they develop their projects. QI Café restarted in May, with the first café being held virtually.

TSH have been selected to display a poster in the NHS virtual event in June 2021 with the winning team from TSH3030 project in 2019, Lewis 1 Striders describing their project, including ongoing development.

Realistic Medicine

Realistic Medicine (RM) is the Chief Medical Officer (CMO)'s strategy for sustaining and improving the NHS in Scotland. It is the CMO's vision that, by 2025, all healthcare professionals in Scotland will demonstrate their professionalism through the approaches of RM.

The six key themes of RM are:

- Building a personalised approach to care
- Changing our style to shared decision making
- Reducing harm and waste
- Becoming improvers and innovators

- Reducing unwarranted variation in practice and outcomes
- Managing risk better

An awareness raising session for all staff on the principles of Realistic Medicine. was delivered by the Clinical Lead through the Seminar Series in May. This was well attended with over 30 participants taking part. Recruitment of a 0.2 WTE Programme Manager to support TSH to continue to embed RM together providing support to Scottish Patient Safety is ongoing.

Collaboration across the wider Forensic Network on Realistic Medicine principles has progressed. Planning is currently underway to host a workshop to be delivered June with RM leads. Scottish Government have recently launched the Chief Medical Officers Latest Realistic Medicine Report 'Recover, Restore, Renew' which has a focus on Covid 19 recovery.

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 March to 25 May 2021, 54 guidance documents have been reviewed. Six were recorded for information and awareness purposes and 4 required completion of an Evaluation Matrix. Of these 4 documents, 2 are currently under review by the Medicines Committee and MHPSG respectively regarding the need for an evaluation matrix to be completed whilst sub groups are being set up to complete a matrix for the 2 others.

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
SIGN	1	0	1
Mental Welfare Commission (MWC)	9	5	3 (2 decisions pending)
Healthcare Improvement Scotland (HIS)	3	0	0
National Institute for Health & Care Excellence (NICE)	41	1	0

As at the date of this report, there are currently 7 evaluation matrices awaiting review by their allocated Steering Group. The progress of the first 2 evaluations from HIS and the MWC was temporarily paused due to The State Hospital adapting to the COVID-19 pandemic however as per Gold Command, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group which recommenced meetings in September 2020. Both the Osteoporosis and Anaphylaxis guidelines required input from the GP which has proven difficult to access. This should resolve now that a Practice Nurse is in post. After some issues regarding availability, the Pressure Ulcer review has now taken place with work ongoing. The review of the Public Health England guideline was unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the meeting and delay in members submitting feedback responses. At the date of the report, two responses are still being sought. The final MWC document will be reviewed in June 2021.

Body	Title	Allocated Steering Group	Current Situation	Publication Date
HIS	From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care	MHPSG (via Patient Safety)	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Evaluation matrix to be revisited upon creation of updated draft Clinical Engagement Policy.	January 2019
MWC	The use of seclusion	MHPSG (via Patient Safety)	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Engagement Policy currently being drafted with seclusion tier 1 and 2 being incorporated. Both to be launched together.	October 2019
SIGN	UPDATED: Management of Osteoporosis and the prevention of fragility fractures	PHSG	Currently under review by Practice Nurse	June 2020
NICE	Anaphylaxis: Assessment and referral after emergency treatment	PHSG	Currently under review by Practice Nurse	September 2020
HIS	Prevention and management of pressure ulcers	PHSG	Meeting to complete evaluation matrix re-arranged 4 times due to Nursing availability was held on 24 May 2021– work ongoing	October 2020
PH England	Managing a healthy weight in adult secure services - Practice guidance	SHC	Meetings required to complete this evaluation matrix within the timescale set by SHC did not take place due to lack of attendance. Two responses from Skye Centre and Psychology still outstanding.	February 2021
MWC	Rights, risks and limits to freedom	Patient Safety	Meeting to complete evaluation matrix arranged for 8 June 2021	

APPENDIX 1

The State Hospital
Realistic Medicine Action Plan 2020-2021

Introduction

Realistic Medicine (RM) is the Chief Medical Officer's (CMOs) strategy for sustaining and improving the NHS in Scotland. Originally published in 2016 as the CMOs annual report, RM has become something of a brand and a social movement. In 2017 the Chief Medical Officer noted her vision for the 'realisation of realistic medicine' in Scotland as being.

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

So, what is realistic medicine?
Realistic medicine puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and care workers to find out what matters most to you so that the care of your condition fits your needs and situation. Realistic medicine recognises that a one size fits all approach to health and social care is not the most effective path for the patient or the NHS. Realistic medicine is not just about doctors. 'Medicine' includes all professionals who use their skills and knowledge to help people maintain health and to prevent and treat illness. This includes professions such as nursing, pharmacy, counsellors, physios and social work.

The development of this Realistic Medicine action plan for the State Hospital both demonstrates the commitment of the organisation to incorporating an RM approach into all appropriate areas of practice, and provides the mechanism through which progress towards this aim is measured and monitored.

Aims and Objectives

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

Realistic Medicine in Forensic Mental Health

However, it is important to understand the context of the State Hospital and high secure Forensic Mental Health care in relation to the implementation of the principles of RM. For example, while the hospital strives to ensure that at every possible opportunity patients are actively involved in a shared decision making (SDM) process, given the nature of our patient population, this is not always as easy to ensure. All TSH patients are detained under mental health legislation. The State Hospital also employs a different understanding of the term Risk in relation to patient care, than that intended within the principles of RM. . Our focus is on risk of harm to others and a major part of our work is on developing individual violence risk and assessment and management plans. All other forms of medical risk such self harm or iatrogenic complications are also relevant to our patients. So, while it is important to note these differences, the State Hospital are clear in our view that these differences should not be considered insurmountable barriers to as full an implementation of the principles of RM as is possible, and accept that in some cases a more innovative approach may be needed to affect positive change within a secure environment.

It is also important that this action plan recognises the ongoing Review of Forensic Mental Health Services being undertaken by the Scottish Government. How the outcome of the review will affect the provision of Forensic Mental Health services in Scotland is as yet unclear, but whatever the outcome both the State Hospital and wider Forensic Managed Care Network will ensure that a Realistic Medicine approach is embedded within the provision of Scottish Forensic Mental Healthcare.

State Hospital Realistic Medicine monitoring outputs

As noted above within the Aims and Objectives section, some of the principles of realistic medicine need careful consideration within the context of high-secure Forensic Mental Healthcare. The table below sets out the overarching range of outputs that the State Hospital will consider in relation to providing evidence of progress against the actions outlined in this plan. Each individual area of work will also have specific outcomes to be measured and monitored and these are included in the action plan itself on page 5.

RM Principle	Range of outputs to be considered	Example
Shared Decision Making	Patient Feedback experience which evidence a personalised approach to care.	Patient engagement in Clinical Model review.

Personalised approach to care	Patient Feedback. Patient involvement in SDM. Case Studies.	Pre-Admission Needs process. CPA Review. CARE questionnaires.
Reduce Harm and Waste	Improvement in existing process.	CPA Review. PoMH audits (Prescribing Observatory for Mental Health)
Reduce unwanted variation	Audit of measurable outcomes noted in action plan to identify variation.	Clinical Pause form audit to identify variation and inform improvement approach.
Manage Risk better	Process changes	HEPMA system reducing medication errors. Grounds Access process change to reduce risk of delay in patients being granted unescorted grounds access.
Become Improvers and Innovators	Increasing QI Capacity and Capability.	QI, RM, VBH training uptake by staff. QI project case studies demonstrating innovative approaches and improvements achieved.

State Hospital Realistic Medicine Communications Plan
Communication plan to ensure that staff understand how we are supporting the practice of realistic medicine in the hospital.

Month	Communication action	Person Responsible	Target Audience
January 2021	Use general staff bulletin to circulate short article on Realistic Medicine, plans to recruit RM Programme Manager, and aspects of ongoing RM work.	RM Lead	All TSH staff
January 2021	Existing Forensic Network communication processes will be used to promote a Realistic Medicine approach across the Forensic Managed Care Network	FN Manager	All FN sites will be included with a request to cascade the communication across all FN staff.
From RM Programme Manager appointment	RM Programme Manager to commence programme of meetings with professional groups, clinical teams, and other appropriate groups to promote RM activity and training.	RM Programme Manager	All staff but targeted approach to specific groups
March 2021	Use specific RM focused staff bulletin or 'Vision' article to introduce RM programme manager and their role, provide more detail on RM activity within TSH, the planned activity as outlined in the action plan, and the training opportunities available to support staff in using an RM approach.	RM Programme Manager	All TSH staff
From June 2021	Provide a regular quarterly RM update to all staff through bulletin.	RM Programme Manager	All TSH staff
All RM related communication	The RM Team will ensure the use of Case studies within the RM related communication to staff. This will provide a link between the principles of RM, and practical examples of work ongoing within the hospital.	RM Programme Manager	All TSH staff

State Hospital Realistic Medicine Governance Process

The State Hospital has a robust existing governance framework for RM, which will be expanded through the addition of the Realistic Medicine Programme Manager role. Realistic Medicine work streams are overseen by the hospital's monthly Mental Health Practice Steering group (MHPSG) which is co-chaired by Dr Gordon Skilling (RM Lead).
Action:

- MHPSG Review of the Action plan as part of work plan
- Communications plan – both initial communication and subsequent communication around progress being made against the RM actions identified.

The MHPSG in turn reports directly to the Hospital's Clinical Governance Committee of the TSH Board.
Action:

- Clinical Governance Committee oversight of RM through submission of RM updates/MHPSG annual report/ QI report.

Case Study: TSH3030

Introduction
The hospital's QI Forum was formed in May 2018 and identified an initiative, originally developed in NHS Ayrshire and Arran, which enabled and engaged staff in quality improvement. This initiative was adopted and became TSH3030. The TSH3030 approach invites teams to form and spend 30 minutes a day for 30 days on a quality improvement project. In October 2018, the TSH3030 initiative was initially launched and teams were invited to put forward ideas for QI and commit to take 30 minutes a day for 30 days to develop and test ideas for making improvements. Teams were supported by mentors from the QI Forum, and feedback from the initial event was very positive;
Feedback from staff included:

- ***'The buzz around TSH3030 was very positive within the hospital'***
- ***'People were motivated to get involved and TSH3030 allowed the opportunity to do something positive'***
- ***'The QI tools we used really helped us to make improvements and understand factors affecting us'***

Feedback from patients included:

- ***'I learned to work in a group and how to organise', 'Fine wee group, enjoyed it'***

The TSH3030 initiative was then run again in 2019.

Outcomes:

- TSH3030 was delivered across the whole system building QI capacity and capability.
- In 2018; Twenty three teams registered and **21 completed** the 4 week initiative, supported by 7 QI mentors. In 2019; 38 teams registered to participate with 28 completing the 4 week challenge.
- **In 2018: 111 multidisciplinary members of staff and 30 patients** worked together to improve the quality of our services. In 2019: 146 staff and 64 patients were engaged.
- **After feedback from the 2018 event, 2 days of QI training was offered to staff before the start of the 2019 event, and many teams benefited from team members taking part in this. Projects got off to a flying start with mentors reporting that many teams were focused on their QI methods and had aims statements.**
- QI methods and approaches became more accessible; teams used more than **20 different QI methods** including process mapping, run charts, patient's feedback surveys and fishbone analysis charts.
- **A number of projects over the 2 years of the initiative have noted that their TSH3030 project** resulted in improved and meaningful therapeutic engagement.

Award:
In 2020, TSH3030 was nominated for, and won, the Royal College of Psychiatry Quality Improvement Team of the year award. The team was delighted to win this prestigious award and receive feedback from the Minister for Mental Health who described the initiative as 'an exemplar model of staff and patients collectively working together to drive forward quality improvement.'.

Action:
While TSH3030 has been a huge success over both 2018 and 2019, the QI forum has been very keen to ensure that QI activity is seen as something that should be embedded within day to day practice at all times, and not be solely linked to a specific time limited initiative. Subsequently the QI forum aims to move from a TSH3030 model to a TSH365 model which will aim to continue to increase our QI capacity and capability, and further embed a culture of quality improvement across the hospital.

State Hospital Realistic Medicine Action Plan

Quality Improvement: Becoming Innovators and Improvers				
Initiative	**Summary of Action**	**Measurable Outcomes**	**Person Responsible**	**Timeframe**
TSH3030/TSH365	See TSH3030 Case Study as above.	Monitor the number of QI initiatives in place under a TSH365 model when compared to success of TSH3030.	QI Forum	2021
Improving Observation Policy (IOP)	The Improving Observation Practice (IOP) work was initially focused on the identification of practice, provision of a consistent approach, investigating what could be considered a restrictive practice for patients, and looking into the staffing requirements with specific focus on level 3 observations. That initial work resulted in the development of a new Observation policy. The IOP team are now taking a QI approach to implementing the new Observation policy within the hospital.	Patient Days on Level 3 Observation. Staff days working on Observation. Days between episodes of Level 3 Observation.	Nursing Practice Development IOP lead	2021
Clinical Pause	The use of the Clinical Pause is now embedded across all four Hubs and is being used regularly as a care planning/risk management process. The next steps are to complete the data entry into RiO and to conduct an in depth audit of all the Clinical Pause meetings to identify any variation across the site and potential areas for improvement. The IOP project is also building the Clinical Pause into the new Continuous Intervention policy to support decision making and least restrictive practices.	Identify any variation in Clinical pause across the site. Use identified variation to support quality improvement approach to clinical pause use. Monitor the use of the clinical pause as part of the IOP Continuous Intervention.	RM Lead	2021
Skye Centre Activity redesign	This project is taking a QI approach to developing the processes used within the hospital to support patient access to opportunities for activity within the hospitals Skye Centre, wards and Hubs. The project will be live for 90 days and will utilise a review of literature, process mapping, and expert interviews to initially develop a project driver diagram. The project will then develop prototypes and pilot to inform the development of a Skye Centre Activity Implementation plan.	Development of implementation plan.	Head of Corporate Planning and Business Support	April 2021
Pre admission specific needs form	The ongoing development of the Pre admission specific needs form and associated process is aimed at ensuring a person	The process should ensure clinical teams have an early understanding of the specific needs of all newly admitted	MHPSG	2021

	centred approach to care, and anticipating any communication difficulties which may impact on the shared decision making aspect of care prior to a patient being admitted to the hospital.	patients to support the early implementation of a personalised approach to care.		
CPA process review	The hospital's Mental Health Practice Steering group have been asked to conduct a wide ranging review into the patient's annual and interim CPA (Care Programme Approach) review process. The CPA reviews are the main process by which clinical teams, the patient and the patients carers review the patients progress over the previous 6 month period and put in place a management plan to support the patients ongoing care. The process involves both a meeting to discuss progress and the planning of ongoing care, and the completion of required paperwork documenting both progress and future care plans. The CPA review will employ basis QI principles, conducting small tests of change to focus on the development of a more patient centred approach.	The aim of the review is to support a more co-productive approach to all aspects of CPA care planning. The project will need to consider the changes that may be brought about by the planned revision of the hospital Clinical Model, and the opportunity for the level of patient involvement and shared decision making to be dependent on the stage at which the patient is in their journey through high secure forensic care.	MHPSG	2021
Reduce Restrictive Practice: Grounds access	Work has been ongoing to identify and address issues relating to a perceived delay in patients being granted full unescorted access to the hospital grounds. This work aims to move the Grounds Access permission process onto an electronic system, reducing the risk of misplaced forms and reducing delays caused by the collation of the necessary range of authorisations.	Timescale from the point of submitting an application for grounds access to the approval of grounds access will be reduced.	MHPSG	Early 2021
Hospitals Electronic Prescribing and Medicines administration system (HEPMA)	The State Hospital is engaged with the national programme to implement HEPMA systems across all NHS Scotland Boards. TSH is working in regional collaboration with NHS Lothian to introduce the system with the aim of reducing harm, and better managing clinical risk.	Full implementation of HEPMA system into practice. HEPMA benefits realisation monitoring will also be in place.	HEPMA Project Manager	Go live roll out aimed for July 2021
Clinical Outcomes Monitoring process	The outcomes process has been in place for some time, providing a high level summary of TSH patient outcomes across a range of outcomes areas specific to FMH care. Engaging staff in the use of this data for improvement has been difficult and work is now focused on	More effective engagement of frontline clinical staff in utilising the wide range of available data to inform and support clinical decision making.	R&D Manager	Link in with SS data review work and implement multi-level Clinical Outcomes Monitoring data approach by July 2021

	identifying ways in which frontline staff can be more effectively engaged in the use of data for improvement.			
Continuous Quality Improvement Framework Reviews (CQIF)	The Forensic Network supports independent quality peer reviews across the forensic estate and into the community. The third round of the Continuous Quality Improvement Framework Reviews is due to commence in 2021.	The CQIF Reviews provide the opportunity for consistent benchmarking and auditing across the forensic mental health estate. Production of standards within the review process which incorporate the principles of realistic medicine where appropriate.	Forensic Network Manager	2021 – 2023

Staff and Patient Engagement: Shared Decision making				
Initiative	**Summary of Action**	**Measurable Outcomes**	**Person Responsible**	**Timeframe**
Safety Survey	The staff safety survey was conducted in the Hospital in response to a period with high levels of inpatient violent incidents. The survey was aimed at engaging staff in conversation over factors seen to support a high level of violent incident and identify mitigations or changes that could be introduced to make the environment safer for staff and patients, with a view to informing the discussions over any change to the hospital's clinical model. The survey was prefaced by analysis of incident data to identify any patterns. The analysis revealed that the majority of incidents involved a small number of patients, and the introduction of Complex Case Reviews supported a reduction in assaultative behaviour. This survey should be repeated once clinical model changes have been introduced.	Monitor the impact of Complex Case Reviews on behaviour of specific patients.	Medical Director	Revisit safety survey once new Clinical Model is in place and staff have had time to assess the impact of the change.
Clinical Model consultation	Once the decision to review the existing Clinical model was made a wider ranging consultation was undertaken with all staff throughout the hospital. Specific innovative approaches were taken to support the staff engagement given the difficulties experienced in reaching all ward-based staff. Consultation included electronic survey, presentations with Q&A as part of nursing handover process, and access to the ward staff training slots on Saturday mornings. Once this period of initial consultation was	Once the new model is in place it will be crucial that an ongoing engagement, monitoring and feedback process is in place to support staff engagement in the shared decision-making aspects of the ongoing continuous improvement approach.	Medical Director	This is dependent on the timeframe for the implementation of the new clinical model which will in turn be impacted upon by the status of the pandemic.

	completed the hospital conducted a rigorous Options Appraisal process to identify the most important factors to consider when revising the Clinical Model, this was again conducted in a consultative way engaging staff from across the organisation.			
Staff Wellbeing survey	The State Hospital staff wellbeing survey was initially conducted in September. The survey was focused on both general assessment of staff mental wellbeing and included validated measure the Warwick Edinburgh Mental Wellbeing scale (WEMWBS), and engaging staff to feedback their experience off the staff support services that were put in place specifically to support staff through the pandemic. The survey will be re-run to assess any change in overall wellbeing, and to continue to inform the ongoing development of staff support services.	Data generated on staff wellbeing from 2 different time points will be analysed. Changes will be made to the Staff wellbeing service within the hospital based on staff feedback.	Staff Wellbeing Survey Principal Investigators	2nd staff wellbeing survey will be conducted in January 2021
Advance Statements	The Advance Statement is a process by which Mental Health patients can make a statement about their wishes regarding their future care. The MHPSG has conducted an audit of Advance statements and further work is ongoing to try and ensure that any advance statement put in place is going to be helpful in ensuring that the patient's wishes can be enacted. Recent data has indicated that the proportion of patients awaiting transfer without an Advance statement has increased, and clinical teams will be asked to address this.	The Advance Statement is a key aspect of supporting a personalised approach to care within Mental Health. The main outcome of the review will be that all Advance Statements in place will have been developed in a co-productive way to ensure they are actionable within the context of high secure care but provide clear advance information on a patient's wishes should their illness affect their capacity to consent to treatment. Monitoring of the proportion of patients who do not have an advance statement will continue with feedback sought from those patients who have made the decision that they do not want an advance statement. This feedback can be used to inform development of the Advance statement process and ascertain how this can be improved.	MHPSG	2021
Carers Clinic	A small project to improve the contact with relatives and carers by conducting a regular carer led carers clinic. This is starting within Mull hub on a pilot basis.	Number of carers attending. Feedback from Carers as to benefit of the clinic.	Mull Hub Project Lead	2021

Citizens Jury Recommendations event	The RM lead had planned a Forensic Network event to discuss the recommendations of the Citizen's Jury on SDM for April 2020. Unfortunately, due to the pandemic the event had to be cancelled but a further event will be arranged for early 2021.	The objective of the FN event will be to review the Jury's recommendations and to develop an action plan to address the issue of SDM within the FN.	RM Lead / RM Programme Manager	2021
What Matters To You activity	The WMTY agenda is inextricably linked to a range of other initiatives including Realistic Medicine and also the Equalities agenda. The hospital Board has been consistently supportive the value and importance of fully engaging with both patients and carers in a meaningful way. The indicators around this area reflect a co-productive SDM focus, and allow flags to be raised on occasions when appropriate engagement may not be in place. This work will continue to gather evidence from both patients and carers.	Examples of work include the Triangle of Care. This process is designed to support patients and their carers in being explicit with Clinical Teams in relation to what is being asked of them in relation to CPA engagement. This in turn supports proactive carer input in relation to the carer view on the patients progress and what can be done better, ensuring a co-productive approach.	Person Centred Improvement Lead	Ongoing throughout 2021
Forensic Network Carer Co-ordinator Group	The Carer Co-ordinator Group is a professional group facilitated by the Forensic Network which aims to bring together carer co-ordinators from across all NHS Health Boards. The group aims to address the needs of forensic carers, share initiatives from all health board areas and be a platform for information sharing and good practice. The Person Centred Improvement Lead for TSH is a member of this group.	Formalised links between services and processes for sharing information when patients move on. Consideration of how to engage carers in a meaningful way. Collaborative work to avoid duplication and provide a joined up service to better meet the needs of carers and patients within forensic services.	Forensic Network Manager	2021

Staff Training				
Initiative	**Summary of Action**	**Measurable Outcomes**	**Person Responsible**	**Timeframe**
QI Training	The State Hospital is committed to utilising available national QI training as is evidenced through our continuing link to the ScLIP and ScIL programmes. However the hospital has also developed and provided its own 'Essentials of QI' training programme for staff. The programme is based on the SIFS course and provided by members of the QI forum. The hospital intranet also includes the 'QI Zone', a QI dedicated area that includes links to a wide range of QI information and training resources. RM will be included as a clear component of the wider QI training initiative. The hospital will also encourage	7 SCN's on ScLIP 3 staff on ScIL Number of staff on Essentials of QI training and plans for online delivery in 2021. Number of 'hits' on QI Zone. Number of staff to complete VBH training modules.	QI Forum	Continuous ongoing aim to increase TSH QI capacity and capability.

	all appropriate staff to undertake the VBH training modules provided through Scottish Government.			
Shared Decision Making online module	Shared Decision making online module to be added to the TSH Learnpro platform as a module available for all staff.	Number of staff who have completed the SDM module.	Learning and Development Dept.	March 2021
Forensic Network Professional Groups	The Forensic Network supports a number of professional groups across the estate to allow colleagues to consider discipline specific issues (e.g. AHP Leads, Forensic Clinical Psychology, Social Work, Pharmacy). The groups offer the opportunity for the RM team to engage with staff to promote RM activity and training across all disciplines in the forensic estate.	Number of staff engaging with RM opportunities through Professional groups.	RM Lead / FN Manager	2021
SoFMH short course training opportunities	The School of Forensic Mental Health (SoFMH) offer a varied range of short courses to forensic practitioners from across Scotland and Northern Ireland. The course list currently includes a QI Training course, but the SoFMH course list offers an opportunity to provide Rm focused training to staff from across the FN.	Use Training Needs analysis data and links to Professional Group leads to ascertain desire for RM focused course.	FN Manager	2021

Impact of Covid and Remobilisation plans				
More personalised approach to patient activity	The various Impacts of the covid-19 pandemic have affected patient care in a number of ways. However, one of the positive outcomes has been the necessity for more of a focus on a personalised approach to care due to the suspension of group work and the household model reducing any mixing between wards.	It is important that any positive benefits of the ongoing restrictions are maintained once the impact of the pandemic has ceased (or at least reduced). The TSH Remobilisation plan will include focus not only on reducing waste and unwanted variation, but also on maintaining some of the innovative aspects of good practice that have been introduced.	Head of Corporate Planning and Business Support	2021 but will depend on progress of pandemic and completion of remobilisation planning.
Better use of technology for patients and staff, and wider Digital Transformation	The impact of the Covid-19 pandemic has resulted in the need to take innovative approaches. The pandemic has resulted in the cessation of all face to face visits to patients. Subsequently a Video visiting protocol has been put in place to support patients in having contact with families over this difficult period. However given the remote location of the State Hospital and the National nature of the patient group (also including Northern Ireland), video visiting will become an	It is important that any positive benefits of the ongoing restrictions are maintained once the impact of the pandemic has ceased (or at least reduced). The TSH Remobilisation plan will include focus not only on reducing waste and unwanted variation, but also on maintaining some of the innovative aspects of good practice that have been introduced. The Forensic Network Communications and	Head of Corporate Planning and Business support	2021 but will depend on progress of pandemic and completion of remobilisation planning.

	important aspect of patient contact with family. The ongoing programme of improvement to the Hospital's eHealth infrastructure is designed to support both staff and patients. It is important to note the limitations in place for patients within a high secure environment in regard to digital technology with limited access a major issue. Patients do not have the opportunity to have IPads, and are also unable to use other systems such as MS Teams. However again the RM team see this as rationale for further innovative approaches.	Technology short life working group has been developed with the aim of supporting the ongoing Digital Transformation agenda.		
Staff wellbeing centre	As noted within the section on the staff wellbeing survey the hospital has put in place a staff wellbeing centre to support staff throughout the pandemic period. This has been an invaluable resource and given the high stress nature of forensic mental healthcare the staff wellbeing centre will be maintained beyond the end of the pandemic period to provide support and advice to staff on ways to support and improve their own mental health and wellbeing.	Number of staff attending Wellbeing Centre See an improvement in Staff wellbeing through the results of the Staff wellbeing survey. Compare WEMWBS scale mean scores across each run of the wellbeing survey.	Staff Wellbeing Group (Monitored through MHPSG)	In place and ongoing. Further development will be informed by 2nd run of wellbeing survey.

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Minutes of the Clinical Governance Committee Meeting held on Thursday 11 February 2021 at 9.45am via MS Teams **CGC(M)21/01**

CHAIR:
Non Executive Director — Brian Moore

PRESENT:
Non Executive Director — Stuart Currie
Non Executive Director — David McConnell

IN ATTENDANCE:
Chief Executive — Gary Jenkins
Consultant Forensic Psychiatrist — Khuram Khan
PA to Medical & Associate Medical Directors — Jacqueline McDade
Head of Psychology — John Marshall
Head of Corporate Planning and Business Support — Monica Merson
Director of Nursing and AHP — Mark Richards
Board Secretary — Margaret Smith
Clinical Effectiveness Team Leader — Sheila Smith
Medical Director — Lindsay Thomson

1 APOLOGIES AND INTRODUCTORY REMARKS

Brian Moore welcomed those present to the meeting. Apologies for absence were noted from Cathy Fallon.

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 12 NOVEMBER 2020

The Minutes of the previous meeting held on 12 November 2020 were amended on page 8, second paragraph, replacing word “review” “with monitoring” and were subsequently approved as an accurate record.

4 PROGRESS ON ACTION NOTES

All actions are progressing or have been completed.

Mental Health Practice Steering Group
Gary Jenkins advised that the digital agenda work is being picked up as a business tableau action to ensure production of data is not as onerous going forward. Action can be closed off.
Action: Jaqueline McDade

Covid-19 update / Covid Vaccinations
This is covered in the Covid-19 report (Agenda Item 6).

CPA / MAPPA Report / Advocacy Monitoring
Mark Richards advised that the Patient Advocacy Service Annual Report has been presented to the Board and there are no issues in terms of their ability to support patients to participate in CPA

meetings.

Physical Health Steering Group Report
Prompt to be given to include relevance of admissions and discharges in future reports.

Learning From Feedback
To ensure that new admissions are being given information on CCTV is part of the communication plan, the Project Board asked that a statement be issued to patients via the Patient Centred Improvement Team to ensure they knew what the upgrade looks like and to advise them on, what we would do with images, etc. Gary Jenkins will discuss with Ken Lawton to ensure the communication complies with GDPR process. This action can be closed off.

Safe Staffing
Gary Jenkins advised that there has been a debate in relation to this report coming to Clinical Governance and Staff Governance and a discussion needs to take place through Staff Governance that the report is for action and that this group notes it to ensure we do not have 2 reports.

Action: Gary Jenkins

Grounds Access
The Committee were advised that the grounds access policy is being developed and is near completion. There is no longer a need to have a short life working group on this as the new policy will resolve issues around delays in patients achieving ground access and automating the process will hugely help.

Supporting Healthy Choices Plan
A progress report is being presented to the Board on 25 February; and work is being undertaken to develop a whole new healthy choices plan which will come to this Committee in 3 months time.

Action: Khuram Khan

5 MATTERS ARISING

Flu Vaccinations
Brian Moore asked about the figures for the uptake of the flu vaccination. Gary Jenkins advised that the uptake was 56% (365), 1% (9) of which related to people being vaccinated at their own GP Practice. This figure is higher than the previous 2 years. Mark Richards advised that the vaccination is still available should staff wish to receive it.

Lindsay Thomson advised that this is being tracked weekly via STAG and Karen Burnett, Senior Nurse for Infection Control, will be making staff aware it is available. It was stopped during the time that the Covid-19 vaccinations were being administered as there needs to be a week between both vaccinations.

Rehabilitation Services
Brian Moore advised that when the Committee receives annual reports, they want to make the connection between the previous report. Lindsay Thomson advised that the Clinical Governance Group, which meets monthly, receive an intermediate 6 monthly report and any issued noted are followed up month on month and if there was a particular concern, an additional report would be added to the Committee workplan.

6 COVID-19 UPDATE

Members **received** and **noted** a paper on the COVID-19 situation presented by Lindsay Thomson, Medical Director, which covers all aspects of the clinical response.

Lindsay Thomson provided an update of the work undertaken since the last meeting around Covid-19.

Incident Command Structure
The incident command structure was stood down on 9 December 2020 and moved to a revised management meeting structure with Corporate Management Team, Organisational Management Team and Hospital Management Team established. This structure will be reviewed after six months. However, following a Covid-19 outbreak on 16 January 2021, a daily Covid-19 briefing was established around the Corporate Management Team before the Incident Command Team was re-established on 30 January 2021.

National Guidance
National guidance continues to be developed and is closely monitored and logged; we continue to follow the Scottish Government route map and Scotland's Strategic Framework which sets out the approach to suppressing the virus and which sets out the 5 levels of protection introduced from 2 November 2020. This led us to move, as a Hospital, to a household model with patients in ward areas of 12 could mix without socially distancing on 4 January 2021, however, with a change in situation and the new variant of the virus, we moved to a mini model of 6 + 6 patients on 8 January 2021.

Test and Protect
Test and Protect has been utilised successfully during the recent C-19 outbreaks within TSH. Test and Protect services are based on standardised algorithms that do not necessarily fit with the TSH setting. Such issues are discussed at a Incident Management Team meeting and decisions taken. These are then shared with relevant TSH, and Test and Protect staff.

Infection Control
Infection Control is instrumental in all we do. Overall 154 patient tests have been taken; 114 on asymptomatic patients, with 13 positive tests, 8 patients during the first outbreak and 4 in the second outbreak. One patient was tested more than once. The 4 patients who tested positive in the second outbreak were all in Lewis 3. As of this morning, one patient remains in University Hospital Wishaw and the other 3 have come out of isolation and can mix with patients in the socially distanced model we currently have in place; these 3 patients have no major ill effects.

A protocol is in place for testing patients entering or leaving the hospital to minimise the risk of infection. Since August we also have had patients moving elsewhere within the estate.

Patient Flow
Over the last quarter there have been 11 admissions and 17 discharges.

Primary Care
Due to illness we currently do not have the services of a GP, however 2 Advanced Nurse Practitioners nurses are providing input via telephone or Near Me to TSH patients. They will attend in person when there is a need to do so.

NHS Lanarkshire Emergency Department Liaison
The contact between NHS Lanarkshire Emergency Department was tested recently and was extremely successful when we had a patient beginning to deteriorate and needed to go to University Hospital Wishaw and got us to where we needed to be without having to go through the general system.

Identification of Patient Comorbidities and Shielding Cases
Shielding recommenced in January 2021 and is relevant to 2 patients within TSH. There are 54 patients with relevant comorbidities and this data was used to determine which patients were priorities to be vaccinated and the vaccine was offered to 14 patients with 13 accepting.

Individual Patient Physical Health Summaries
Patient health summaries remain up to date and are readily accessible.

Hospital Transfer Plan
Transfer plans agreed in advance with the Scottish Government for patients who require to be transferred as a result of Covid-19.

Coronavirus (COVID-19) TSH Staff Guidance on Management of Patients
The guide for what ward staff should do if any suspected case remains in place and is updated by the Senior Nurse for Infection Control.

Interim Clinical and Support Services Operational Policy (version 18)
The Policy is subject to regular review and is maintained by Mark Richards.

The current model being operated is a social distancing model where within each ward patients up to a maximum of 3 in a group and it must always be the same group, is out and about within areas of ward at the one time but they must maintain 2m social distancing from each other to minimise the spread of infection. We have 9 patients who are unable to tolerate periods within their room. Patients can be out and elsewhere or on grounds access; those who cannot manage this model will have an individual care plan with a focus on keeping them separate to avoid the spread of infection. This is monitored by the Operating Model Monitoring Group (OMMG), which meets weekly.

TSH COVID-19 Clinical Care Support Documentation
The Clinical Care Support Documentation was developed to assist in the care of patients who have COVID-19 within Hospital**.** This document was fully updated to Version 3 on 4 November 2020.

General Medical Ward
This ward in Arran 3 has not been required to be used.

Personal Protective Equipment
There are no issues around PPE. Retesting of fit masks is currently underway due to supply and design changes.

Overnight Duty Room
The overnight duty room had to be used as a result of heavy snow by our on call trainee Doctors.

Visiting
There is no visiting at the present time. We continue to monitor video visiting usage.

Enhanced Surveillance Reporting-
The Enhanced Surveillance reporting process has continued to be conducted through the STAG group on a weekly basis. This has been further extended to include data on vaccinations and lateral flow testing.

Scientific & Technical Advisory Group (STAG)
STAG continues to meet weekly. The following recommendations / changes have been implemented in the last quarter:

- Tier 4 restrictions – applied within TSH – Hairdressing to cease / gym access for staff to cease and TSH to adopt process dependant on level set by Scottish Government – 17/11/20
- Introduction of Household Model 11/12/21 (12-same)
- Creative activity in craft and design to be undertaken in the Skye Centre on a 1:1 or small group basis with patients from the one ward - 15/12/20
- Hospital visiting suspended from 26/12/20
- Introduction of Mini Household Model (6+6 - same) 8/1/21
- Patient vaccinations 1/21

- Introduction of Social Distancing Model (maximum of 3 – same) and closure of Skye Centre 1/2/21.
  Any ward with C-19 positive patients is placed in isolation.

Patient Feedback and Engagement
The Learning from Feedback report is on the agenda for discussion today.

Staff and Patient Vaccination
500 members of clinically facing staff and 13 vulnerable patients have been given the first dose of the Pfizer vaccine. The last vaccination clinic was held on 22/1/21. All will receive a second dose twelve weeks after their initial vaccination. 60 staff members declined vaccination. Permission was obtained from Scottish Government to utilise any excess vaccine on the vulnerable patient group. Excess vaccine arose because of a change in product licence use that allowed six rather than five vaccine doses to be taken from each vial. The dose did not change.

3.18 Lateral Flow Device Testing
This was rolled out within TSH in late December 2020 and early January 2021 in line with Scottish Government instructions. In total 548 staff members were issues with a test kit. Testing should be carried out twice per week. To date 1260 tests have been reported on the Scottish Government system. Use of LFTs and reporting of results is being actively promoted.

David McConnell stated that the vaccination roll out was a tremendous achievement and offered congratulations to all involved. In relation to patients being unable to tolerate a more restrictive model, David McConnell asked what typically this involves and what might be the implications for infection control. Lindsay Thomson advised that this will be someone who cannot be isolated in their room and will involve when their own group of 3 are not up they will be in a side room with nursing staff ensuring they do not mix with other people; they may have staff by their side. Part of their plan should be how do they get out to access fresh air and what other activities can they do; all of this has to be with keeping them away from others who do not belong to their particular group of 3. There may be individuals who would normally eat on their own for a variety of reasons, for example, Intellectual disability patients or patients with dementia who would struggle in groups.

Stuart Currie asked, in terms of lessons learned, if there were areas we think there is good practice? Figures around vaccinations have been impressive; how do we maximise uplift in flu vaccination in the following year? Gary Jenkins advised that there is a flu vaccination challenge and 55% is a high number for the State Hospital. Discussions have taken place over the past week with the National Chief Executives Group as there will be an annual plan for Covid vaccinations going forward and when we stand up the flu vaccination do we do the two at the same time; this may prove difficult to operate as not everyone takes the flu vaccination. There will be a process going forward looking at mass vaccination of the population.

Gary Jenkins advised that there are 160 or 170 data items of improvement that came about from the recovery and innovation process, the majority of which are underway and delegated to other groups. Learning items are embedded or deliverable through different processes and multiple reports. The Clinical Model was to try to take some measures and understand how the change in clinical model could affect what this would look like.

The Committee noted the report.

Aileen Burnett joined the meeting at this time.

7 MENTAL HEALTH PRACTICE STEERING GROUP 12 MONTHLY REPORT

Members **received** and **noted** the Mental Health Practice Steering Group (MHPSG) 12 monthly report, presented by Aileen Burnett, Consultant Forensic Clinical Psychologist. The paper sets out the activities of the group during 2020 and highlights future areas of work.

The activity of the group is largely based around key safe, effective, person-centred areas of service delivery in the context of reviewing and monitoring clinical practice within the Hospital; including Psychological Services input data; risk assessment completion; Relational Approaches to Care; Trauma Informed Care; Person centred improvement projects, Equality Outcomes; intelligence emerging from stakeholder feedback and trend reports.

Over the last 12-month period the MHPSG were involved in the review of 22 guidelines / standards. 8 were deemed to be either not relevant or were covered by a similar guideline. Of the remaining 14 guidelines / standards, 13 of these had varying degrees of relevancy to mental health services within The State Hospital and were sent out for information purposes. Recommendation reviews were undertaken for the 1 remaining guideline / standard.

The project to include Grounds Access forms on RiO has been put on hold by Security. A new Grounds Access policy is due to be published soon and at that time a full audit will be carried out to monitor the time from initiation of the process to the patient being granted access to see if there is anything to be improved upon.

The MHPSG submitted a proposal to the Clinical Governance Group in June 2020 to review the CPA processes in TSH. To date there has been limited progress with this piece of work. A significant challenge has been devising the scope and specific aims of the review in the context of the pressures on the service during the pandemic. At the November meeting of the MHPSG, it was agreed we would process map the current CPA processes with a representative MDT to identify specific areas for improvement. A strategy can then be devised to progress specific improvement areas within the CPA process. It was felt that there was sufficient internal feedback (including patient feedback) regarding the problems and challenges with the CPA process. There is likely to be further consultation required with external stakeholders.

The CPA review is also relevant to other initiatives within TSH including the Renewal and Recovery strategy, changes to the Clinical Model and Realistic Medicine. So aligning it with other projects will be important to ensure a consistent approach and avoid duplication. This remains a priority over the coming year.

Lindsay Thomson advised that the MHPSG are dealing with 2 important areas with the CPA and outcome measures and these are central to what we do with the patients. Lindsay Thomson asked if the MHPSG would be developing an overall workplan that the organisation could be sighted on what the group were doing and likely timescales.

Aileen Burnett responded that a draft of the workplan will be bottomed out when process mapping is underway and will be shared with the wider hospital.

Brian Moore asked about out of date risk assessments. Aileen Burnett advised that there is no issue with the completion of risk assessments, they are only out of date due to month end reporting.

Brian Moore asked if there could be an improvement in clinical outcomes and engagement with clinical teams. Aileen Burnett advised that this will be linked with the CPA review and there is work to be done to make it come alive to teams.

The Committee noted the report and approved the activities and areas of work the group intends to focus on over the next year.

Aileen Burnett left the meeting at this time.

8 PSYCHOLOGICAL THERAPIES 12 MONTHLY REPORT

Members **received** and **noted** the Psychological Therapies 12 monthly report, presented by John Marshall, Head of Psychology. The report covers the period from January to December 2020.

In summarising the report, John Marshall advised that:

86% of patients were engaged in some form of psychological intervention. Prior to the pandemic we were successful in delivering group therapies which we have not been able to deliver this year due to the pandemic and interventions or content of group work was delivered on a 1:1 basis.

In the last annual report, the PTS Team were working with NHS QI on QI improvement methodology then review to develop more efficient sequencing of group therapies. This project has been adversely impacted by the pandemic but will continue. A further QI project from the previous report was to improve the quality and consistency of assessment and formulation by using an audit methodology. This is ongoing.

There have been some challenges over the last year in terms of key performance indicators.

Consideration has been given on how to deliver group work on a digital basis. A short life working group identified steps to be used on how best to deliver group work by group means:

- A rapid literature review on the efficacy and effectiveness of virtual group-based psychological interventions.
- Identification of a platform suitable for the needs of the State Hospital (Zoom, Microsoft Teams etc.)
- Consideration of hardware required alongside IT Security and Information Governance issues.
- Piloting of a virtual group.
- Introduction of virtual groups for other TSH group-based psychological interventions

It has been advised that Teams cannot be used for patients for various security reasons, therefore we need Information Governance and IT to come up with a platform that will help deliver that is safe and secure to use on laptops.

A Planned QA topic is taking forward the Trauma Informed Care programme and to make it a meaningful intervention. There is also a plan to begin discussions on how to take outcomes forward as CORE may not be the right measure for our patient group.

David McConnell stated that he liked the inclusion of comments from members of the team. He asked John Marshall how he would characterise the impact of not being able to deliver some of the activities.

Mark Richards stated that he was pleased to hear about the focus on the use of digital technology and asked what is happening throughout the rest of Scotland. John Marshall advised that 2 Boards are using Teams currently and one is focussed on teams for group work. This is not in forensic settings but in adult mental health. In John Marshall's view, teams is ideal for team work but we have been advised that we cannot go ahead using this as a platform and this is a discussion he is keen to take forward.

Lindsay Thomson advised that a paper is being presented to Gold Command which sets out the various platforms we can use and issues for Gold to make a decision on as this is the way forward. Gary Jenkins advised that there are a range of options to be considered and one of the platforms being looked at enables us to identify if there is more than one person in the room. Progress on this will be routed through the Board.

Brian Moore advised that Cathy Fallon had e-mailed some comments on the report and these can

be picked up outwith the meeting, and highlighted that she was impressed with the use of the library café.

Brian Moore asked if the 2 trainee health psychology trainees would be undertaking any research and how would they evaluate outcomes in terms of obesity and health. John Marshall advised that a meeting had taken place with Lindsay Thomson to discuss a range of issues around research on outcomes on patients in high security so this will be addressed. One of the trainees has a research project looking at staff support online and the efficacy of staff supported interventions; the healthy living steering group look at psychological aspects of healthy living and have delivered a healthy living programme and tried to measure BMI and attitudes and behaviours around healthy living; more global outcomes need to be agreed by the Physical Health Steering Group.

Lindsay Thomson advised that it is very helpful having health psychology trainees and asked if we should have an ongoing trained health psychologist with us given the focus on psychological health issues. John Marshall advised that there are barriers around accepting change and the different range of psychological disciplines and ways of working which would need to be overcome first.

The Committee noted and approved the annual report.

9 Clinical Governance Group 12 Monthly Report

Members **received** and **noted** the Clinical Governance Group 12 Monthly Report summarised by Lindsay Thomson, Medical Director. The report provides a summary of the work of the Clinical Governance Group over its fourth year. The main areas included are:

- Summary of core activity including the reports that were tabled at Clinical Governance Group for discussion/comment prior to going on for approval at Clinical Governance Committee
- Comparison with last years planned quality assurance and quality improvement activity although much of this was impacted due to the national restrictions placed on the hospital due to Covid-19
- Quality assurance activity during 2020
- Quality improvement activity during 2020
- Planned quality assurance/ quality improvement activity for 2021, although this may be impacted on restrictions imposed nationally re Covid-19

Clinical Model, obesity, patient activity and realistic medicine were paused due to Covid-19. Changes to the current clinical model have caused issues in terms of obesity.

There are 6 principles of realistic medicine that apply to the State Hospital and we have a realistic medicine plan which has been agreed with the Scottish Government; we have a Realistic Medicine Lead and funding for a year for a project manager for one day per week to lead on the realistic medicine plan. The hospital's TSH30:30 project won Best QI Team at the Royal College of Psychiatrists annual awards.

The Mental Welfare Commission State Hospital Visit Report was very positive with only one recommendation around activity. This gave the Group great assurance that the processes in place within the hospital were working well.

There was also a Mental Welfare Commission for Scotland Report on Announced Visit to Iona and Lewis hubs in August 2020. There were no recommendations from this report although there were comments around meal times which arose through patient feedback and which have been resolved.

The Variance Analysis Tool (VAT) is a mechanism for ensuring how we deliver care to individuals with the clinical team, patient and carers. The VAT is extremely important to us and there is

nothing worrying about clinical team attendance.

Pre transfer visits were agreed with the Scottish Government that these would be undertaken visually and in person should be the exception to prevent the spread of infection. This applies across the forensic network.

Planned QA/QI activity for next year includes clinical model, physical health and realistic medicine.

Stuart Currie asked how we stop looking at things through Covid lenses as we go forward.

Lindsay Thomson advised that the key for us is to look at the priorities we had before Covid and the priorities set here. The clinical model arose from staff safety concerns and changes in the patient population and a very inclusive approach was taken to this piece of work. The clinical model has 9 principles of how we deliver care but we are unable to move patients whilst we have Covid but as we move in to Spring we will be able to look at what that is like for our patient population as staff will be fully vaccinated and it is hoped that some of our patients will also be vaccinated at that stage. We can move forward with realistic medicine work and patient activity can be increased.

Gary Jenkins advised that direction overall in terms of forensic mental health will be determined by the Barron review.

The Committee noted the report.

10 MEDIUM AND HIGH SECURE CARE STANDARDS ACTION PLAN

Members **received** and **noted** the Medium and High Secure Care Standards Action plan summarised by Sheila Smith, Clinical Effectiveness Team Leader.

Sheila Smith advised that a peer review visit took place in April 2018 to assess The State Hospital against the standards. A report was issued and an action plan agreed. This paper gives an update on the actions agreed.

37 actions were assigned in total. These were split into:

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

As at 31 January 2021 4 actions are outstanding:

1 high graded action is outstanding and this is due to the hospital being unable to transfer patients between hubs due to current national restrictions
2 medium graded actions: 1 relates to suicide awareness training which should be live this month and 1 relating to digital inclusion which should be completed by the end of June
1 low graded action around the CPA process which will hopefully be completed by August

Gary Jenkins asked if we were due to be inspected again. Lindsay Thomson advised that this will be addressed at the Forensic Network Inter Regional Group to get agreement that staff would be available to develop the standards.

The Committee noted the report and progress made.

11 LEARNING FROM FEEDBACK

Members **received** and **noted** the Learning from Feedback report summarised by Mark Richards, Director of Nursing and AHPs for the period 1 October to 31 December 2020.

A wide range of methods continue to be utilised to share feedback. Despite being unable to meet currently as a group, all members of the Patient Partnership Group continue to be supported to elicit views from peers and share them with the Person Centred Improvement Team, either in person, or via the ward Suggestion / Feedback Boxes.

There are a number of themes emerging from feedback shared:

- Frustrations around the restricted visiting model due mainly to national guidance.
- Dissatisfaction with the quality of patient catering as a result of changes to practice influenced by the need to mitigate Covid-19.
- Patient shopping experience.

Over the reporting period 83 pieces of feedback were offered, with the most common theme around meals, which was largely due to what was offered at lunchtime and in the evening and we have now reverted back to pre-Covid with a lighter meal at lunch and a larger meal in the evening.

35 suggestions/comments/general enquiries were shared. One was around the purchasing of confectionery for Christmas presents from external procurement, with a protocol developed for a one off external purchase of confectionery for gifts.

10 concerns were shared around catering and meal time experience and family contact.

7 compliments were received, with positive feedback around families being able to visit over Christmas and staff in the Person Centred Improvement Team giving up their time on Christmas Day to ensure that visits were able to take place.

Page 7 of the report highlights the use of the creative methods used to illicit feedback from the intellectual disability group.

Stuart Currie stated that this was a very impressive report in terms of the variety of issues raised and the responses noted instils confidence in the system being used.

Brian Moore noted that Cathy Fallon had commented in her e-mail that it was very useful to see how issues are dealt with so pro-actively.

The Committee noted the content of this report and its relevance in relation to remobilisation of services through the local service recovery model.

12 LEARNING FROM COMPLAINTS

Members **received** and **noted** a report on Learning from Complaints which was presented by Margaret Smith, Board Secretary. The report shows the type and sources of feedback received and covers the period 1 October to 31 December 2020.

During this quarter, 11 complaints were received and 11 complaints were closed. There were seven complaints which were managed at Stage 1 of the MCHP and four at Stage 2, with one case being escalated from Stage 1 to Stage 2. The Patient Advocacy Service provided advocacy support in three cases.

The report shows that Staff Attitude and Clinical Treatment accounted for the majority of issues raised, and details the outcomes in each case, as well as the timescales for concluding cases. It is confirmed that no new complaints were escalated to the SPSO in this quarter.

The Clinical Governance Committee was asked to note in particular the areas of improvement,

wherein action was taken to improve service delivery directly following the expression of dissatisfaction through the complaints process.

The Committee was also asked to note that as part of the interim management structure established on 9 December 2020, the delivery of the complaints service is now through the Corporate Team with the Board Secretary taking responsibility in this area.

Margaret Smith advised that up until now the Committee have been receiving reports on complaints and feedback separately but work is in progress between herself, Mark Richards and the Person Centred Improvement Team to see how they can bring reports together and provide one report that covers the whole range of patient feedback and complaints.

David McConnell advised that there appears to be some discrepancy in the figures in tables 2.3 and 2.4, particularly around staff shortages and staff attitudes and behaviour and asked that Margaret Smith look into this and provide feedback.

Action: Margaret Smith

Stuart Currie stated that complaints are often a proxy for something else and it may be something that leads to other discussions and asked how we do that. Lindsay Thomson advised that we used to have a 4Cs report which was Complaints, Comments, Concerns and Compliments and we deliberately had that range as sometimes people do not want to complain but there is a concern; the national complaints process required us to have a stand alone complaints report but she is happy with these being brought together into one report.

Mark Richards advised that there have been some improvement in staff shortages as a consequence of flexible working and quarter one was when we were operating a lockdown model for a lot of that time with patients in their room more often with less contact with staff and less conflict.

Lindsay Thomson advised that staff and patients have come together in a time of crisis and risen to the challenges of covid-19, with the patients understanding and accepting the variations.

Gary Jenkins advised that a lot of work has been done on staff shortages and this has seen a significant improvement with a potential bank being established to give more flexibility. He also advised that a couple of complaints relate to one individual and although total numbers may be significant, they can be attributed to one person who complains constantly.

Brian Moore asked what training was available for staff as the SPSO are keen to provide training on complaints management. Margaret Smith advised that she has been involved in the past in train the trainer sessions with SPSO and will pick up on this and try to ensure there is more formalised training across all staff groups across the hospital on how to deal with complaints at the frontline.

The Committee noted the report.

David McConnell left the meeting at this time.

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. The report provided an overview of activity of incidents and patient restrictions for the period from 1 October to 31 December 2020.

- PAA activations have been similar over the quarter with activations in all hub. Two of PAA activations were for patients on the grounds, both on same day but different incidents, when the patients assaulted escorting staff

- Patients are given the choice to provide a sample either urinalysis or oral fluid test. As you see the majority of the patients opt to use the oral fluid test. There was one positive oral fluid test for a patient in Mull 2. He tested positive for methadone.
- There has been a limited number of clinical appointments and ECT appointments taking place during this quarter.
- During October, one patient required to use SRK's to go on an emergency outing.
- During November, one patient required to be double cuffed for emergency clinical outing
- There was 1 'High' incident reported during this period in which information was leaked to the media.
- The number of 'finally approved' incidents increased this quarter from 223 to 231: an increase of 8.
- 'Behaviour' made up the majority of Health and Safety Incidents with 29; this is a decrease of 19 from the 48 incidents reported in the previous quarter. 1 'Behaviour' incident resulted in the Incident Command structure being enacted with a Category 2 review commissioned thereafter. This was approved by CMT on 4 December 2020.
- 'Verbal Aggression/Abuse' increased from 5 to 11 in Q2. 6 were 'patient to staff', 2 were 'patient to patient' and 3 incidents were 'carer to staff'. 8 incidents took place in Iona wards and 3 in Arran wards
- 'Assault' incidents increased from 6 to 7. All 7 incidents were 'patient to staff'. Incidents came from a mix of patients in different hubs. This is being monitored due to the Covid-19 situation.
- 'Attempted Assault' increased from 11 incidents to 18. All 18 incidents were recorded as 'patient to staff'. 8 Incidents came from 1 patient in Mull 2. The rest of the incidents came from a mix of patients. This is being monitored due to the Covid-19 situation.
- 'Staff/Patient Injury' increased from 0 to 5 in Q3, there were no significant findings from the incidents.
- 'Sexual' Incidents decreased slightly from 8 to 7 in Q3. 3 of these incidents came from a patient in Iona 3, 2 being classed as "inappropriate conversation" and another as "sexual assault". The rest of the incidents were from various patients in different wards. All were classed as "inappropriate conversation"
- Staff Resource' incidents reported increased from 27 to 30.
- 'Self-Harming Behaviour' increased from 19 to 22: 8 different patients were reported as having self-harmed in this quarter down from 10 in Q2. 9 occurred in Iona 2 with 2 patients accounting 4 and 5 incidents respectively. 8 incidents occurred in Mull 1 from 1 patient. The other incidents occurred in other wards between Iona and Mull. These incidents are being monitored due to the Covid-19 situation.
- There was 1 patient death in Q3. Patient became unwell on the ward and was taken to hospital where he passed away after palliative care.
- No patients met the criteria on the patient assault tracker.

Please note that the above incidents are being continually monitored due to the Covid-19 situation

- Breaches' increased from 7 to 8 incidents in this quarter. The incidents reported included doors being left open (5), issues with approved contacts (3) and missing items (3)
- 'Other' incidents increased from 4 to 5: the incidents related to calls to ward (3), staff taking home ward phone and patients exchanging goods on the hospital grounds.
- 'Clinical Waste' incidents related to staff not adhering to Linen Segregation, Bagging and Tagging National Infection Prevention & Control Manual. Incidents have increased from 6 to 18 in this quarter. 10 Incidents occurred in Arran, 4 in Iona, 3 in Lewis and 1 in Mull.
- The 'Patient Physically Unwell' decreased from 7 to 4. There were 3 instances of patients experiencing seizure like symptoms and 1 of patient choking.
- 'Equipment Malfunctions' remained at 16 incidents: the incidents reported related to; PAA issues (4); faulty door locks (4); TOA Failure (3); Coretech (2), toilet flooding and faulty floor buffer.
- 3 patients were secluded over the quarter with 6 seclusions in total

- Cat 1 Incident Command (Lewis) 20/02 has been approved.
- Cat 2 PS Incident 20/02 has been reviewed and approved.
- Redaction process in being reviewed and will published when complete alongside Cat 1 20/02, Cat 2 20/01.

Brian Moore advised that there is an emerging improvement in the time taken to complete Cat 1 and Cat 2 reviews and hopes that this will continue.

The Committee noted the report.

14 SAFE STAFFING REPORT

Members **received** and **noted** the Safe Staffing report presented by Mark Richards, Director of Nursing and AHPs. The report covers the period from 1 October to 31 December 2020.

There are a number of factors affecting the delivery of adequate staffing levels such as sickness absence, vacancies and health restrictions/unplanned leave. This report details this along with the current staff in post.

If the preferred staffing levels are not achieved, a DATIX incident report is completed for each event and these will be detailed in this report.

The funded establishment for the wards totals 293 whole time equivalent (wte) staff. The current staff in post is 290.5 wte.

Sickness absence during the reporting period was higher than we would have liked it to be and there has also been an impact on special leave in relation to covid-19.

No business continuity measures have required to be put in place during the reporting period.

There is a continued focus on retire and return to bring more staff into the organisation and there is a plan to engage with higher education establishments, particularly the University of the West of Scotland to recruit for registered nurses during March and April. 11 nursing students joined the State Hospital workforce in April 2020, employed as band 4 staff. All of these staff have subsequently been employed on permanent registered nurse contracts. Staff employed on the Nurse Pool, who responded to the request for retired nurses to return to the workforce all remain in post, working on a part time basis

Daily resource management meetings take place when any staffing challenges are considered and this feeds in to the daily huddle on site.

Lindsay Thomson asked if safe staffing legislation has re-started and where will this sit in terms of other groups. Mark Richards advised that it has not re-started in any great way as a consequence of covid-19 and there has been no date set as yet to do so. He is not aware of any activity required to take forward.

The Committee noted the report.

15 DISCUSSION ITEM

There was no item for discussion at this meeting due to Covid-19.

16 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee noted one area of good practice:

- Responsiveness of staff during Christmas for patients and carers

There were no areas of concern noted.

Gary Jenkins advised that an issue raised at a previous meeting around compliance in relation to PPE in response to Covid-19 and also around hand hygiene compliance which require to be closed off. Infection Control were putting in compliance audits and feedback would be taken through the Infection Control Committee but there has been no update to this group.

Mark Richards advised that action has been taken to respond to the concern and Karen Burnett, Senior Nurse for Infection Control has had 1:1 meetings with senior nursing staff. The Infection Control Committee met last week and there are no specific concerns around hand hygiene.

Brian Moore asked that it would be helpful for the Committee to have a paper circulated with the detail of the outcome of the hand hygiene audit which will give assurance the issues have been captured. These can then be discussed under matters arising and closed off as appropriate.

Action: Mark Richards

17 WORKPLAN

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

18 ANY OTHER BUSINESS

No other business raised at this time.

19 DAY, DATE, TIME AND VENUE FOR NEXT MEETING

The next meeting will be held on Thursday 6 May 2021 at 9.45am via MS Teams

The meeting concluded at 12.45pm.

Approved as an Accurate Record

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM **CF(M)21/02**

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

Present:

Dr Aileen Burnett	*Consultant Clinical Psychologist*
Sandie Dickson	*Person Centred Improvement Lead*
David Hamilton	*Social Work Team Leader*
Dr Sheila Howitt	*Consultant Forensic Psychiatrist (**Chair**)*
Jim Irvine	*Clinical Liaison Security Manager*
Sheila Smith	*Clinical Effectiveness Team Leader*
Fiona Warrington	*Clinical Pharmacist*
Julie Warren	*Corporate Services*

Apologies:

Alan Blackwood	*Lead Nurse*
Dr Jana De Villiers	*Consultant Psychiatrist*
Carolin Walker	*Professional Nurse Advisor*

In Attendance:

Josie Clark	*Senior Nurse Practice Development*
Gary Jenkins	*Chief Executive Officer*
Julie Warren	*Corporate Services (**Minutes**)*

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

The Forum Chair, Sheila Howitt, welcomed everyone to the meeting and apologies were noted.

NOTED.

2 CONFLICT(S) OF INTEREST

There were no conflicts of interest declared.

NOTED.

3 APPROVAL OF PREVIOUS MINUTES

The minutes of the previous meeting held on Tuesday 26 January 2021 were approved as an accurate record.

APPROVED.

4 URGENT MATTERS ARISING

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

NOTED.

5 REVIEW OF ROLLING ACTIONS LIST

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

NOTED.

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

(a) Nursing and Allied Health Professions Advisory Committee

Members **received** and **noted** the approved Minutes of the Nursing and Allied Health Professions Advisory Committee held on 23 February 2021.

In relation to the Senior Charge Nurse Handbook, the Forum felt it beneficial to gain sight of this information to review the Senior Charge Nurse induction programme. Sheila Smith agreed to circulate the document to members and Mr Gary Jenkins.

Action: Sheila Smith

Members noted the positive 33% response rate of the Staff Wellbeing survey.

Sandie Dickson highlighted the additional avenue to utilise the Family Centre for the purpose of Clinical Supervision going forward.

In relation to PPE proposal feedback, Sandie Dickson advised that she met with Alan Blackwood to appraise him of patient feedback. Stakeholder feedback from patients provided two conflicting views from patients was received in that one group felt this raised concern and anxiety and the second cohort expressing that they may feel more at ease with the familiar face and would be better trained. As a result of opinions expressed, no consensus was reached.

NOTED.

The Forum Chair moved to item 11 to allow further discussion on this topic.

(b) Medical Advisory Committee

Members **received** and **noted** the approved Minutes of the Medical Advisory Committee held on 8 February 2021.

Approval of the Grounds Access Policy approximately two weeks ago was noted. Mr Jenkins advised he would suggest to Director of Security, Risk and Resilience that a six month audit would be carried out and brought to the Corporate Management Team and Clinical Forum thereafter for independent oversight. Audit would consist of variance and equality analysis. Julie Warren agreed to add this to the Forum workplan and agenda for July 2021.

Action: Mr Gary Jenkins / Julie Warren

AGREED.

Jim Irvine advised that he was previously involved in conversation and debate on grounds access process within the Intellectual Disability Service and advice sought from the Central Legal Office was that restrictions would be based on protected characteristics in that the argument base would be on current risk behaviours to maintain safety rather than any specific diagnosis. Sandie Dickson advised that she would expect the Equalities Department at the Scottish Government to offer a conflicting view. As the accountable officer, Mr Jenkins advised that he would review the balance of reasonableness component from that of legislative and the risk perspective.

NOTED.

(c) Psychology Professional Practice Meeting

The Forum recognised Psychology Professional Practice Meetings were not taking place at this time, however Aileen Burnett offered key topics of discussion within the directorate. The psychology team had representation on the Digital Inclusion Groups. Mentalisation based programmes had not yet commenced. There was a demand on VC units which Director of Nursing, AHP's and Operations took on board and approval was granted to order further units. Sandie Dickson advised that there was a VC unit available in the Family Centre if required. The Route map from the Scientific Advisory Group is awaited with interest. Patient vaccinations were also of key discussion.

NOTED.

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

Members received and noted the written update from Skye Centre Manager dated 15 March 2021.

The Forum Chair advised that contact was made with Jacqueline Garrity, Skye Centre Manager, to offer the Forum's support regarding the ongoing issues with GP provision.

Mr Jenkins advised that he previously sought assurance and impacts of the drop in GP attendance via the Corporate Management Team. The largest issue was around annual physical health examinations.

In relation to the flexibility around the Service Level Agreement with GP Service, the Forum Chair agreed to make contact with Dr Duncan Alcock, Associate Medical Director to seek further information around the resilience component of the situation should this occur again in future,

Action: Sheila Howitt

Sheila Howitt also agreed to contact the Health Centre Administrator to provide data on the use of Near Me for the next meeting. Julie Warren agreed to add this to the agenda.

Action: Sheila Howitt / Julie Warren

The Forum noted that the position of Practice Nurse within the Health Centre was now filled.

NOTED.

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

The Forum Chair attended the Area Clinical Forum Chair's Group on 10 March 2021 and appraised members of key items of discussion. Of note, were the redesign of care, remobilisation strategies and how to take forward, impact for medical students and clinical placements. There was also discussion around staff wellbeing, with praise for the improved import this has been given during the pandemic but questions on how this fits with occupational health and support for staff with ill health.

NOTED.

8 UPDATE FROM DIGITAL INCLUSION GROUP – TERMS OF REFERENCE AND ACTION PLAN

Members **received** and **noted** the Workplan and Terms of Reference of the Digital Inclusion Group. Progress was noted with each individual activity listed.

Members agreed that this item remain on the agenda for the Clinical Forum in May for continued review. In particular, the use of tablets on the ward with patients for ordering items etc. was

discussed.

Action: Julie Warren

NOTED.

9 UPDATE ON IMPROVING OBSERVATION PRACTICE POLICY

Josie Clark joined the meeting at this point.

Ms Clark offered an overview on Improving Observation Practice Policy for the benefit of the meeting. The Policy was rewritten in September 2020 and initial feedback was received though was paused due to the pandemic and various other challenges. Work has now recommenced and Ms Clarke advised she would be meeting with Director of Nursing, AHP's and Operations to discuss and determine a clear timescale for roll out. A meeting with Lead Nurses and Senior Charge Nurses was scheduled for 5 April 2021 to obtain feedback from this cohort of staff also.

Ms Clark advised she was in touch with Claire Lamza at the Mental Welfare Commission to seek assurance on the hospital being unable to provide data on Level 2 should this be requested.

Ms Clark also intends to meet with Dr Gordon Skilling and is hopeful that he would act as linkage between the hospital and the Mental Welfare Commission going forward.

Ms Clark advised that she would update the Forum electronically to provide an update on further developments for the Forum in May 2021.

Action: Josie Clark

NOTED.

10 CEO UPDATE

Mr Gary Jenkins updated the Forum on the key drives for 2021 and key components for the following 12-month period. Of note was written acceptance from the Scottish Government of the TSH Remobilisation Plan, the requirement to introduce and implement the new clinical model; potentially within the second part of 2021 dependant on the state of the pandemic, Security Tender in relation to the Security Refresh, the provision of a female High Secure Service in Scotland and creating immediate outcomes from the Forensic Estate Review and the potential creation of the new Board.

It was highlighted that Monica Merson, Head of Corporate Planning and Business Support, was producing a workbook on data performance. The Forum Chair agreed to seek sight of this for an overview.

Action: Sheila Howitt

NOTED.

11 DISCUSSION OF FORUM'S VIEWWS ON REPORT PREVIOUSLY SUBMITTED TO SMT ON PMVA RELATED PERSONAL PROTECTIVE EQUIPMENT

Discussion under this item continued from item 6a.

Members recognised that the document provided was outdated and GJ stated this should be marked 'uncontrolled' going forward.

Gary Jenkins advised that this work was a component of continued work on dealing with adverse

circumstances, which was being undertaken alongside the Risk Management Facilitator.

Mr Jenkins advised that work on communications with Police Scotland and a protocol for use of Fire Arms was underway and the interface was Mr David Walker, Director of Security, Risk and Resilience.

Mr Jenkins advised of the legal position of the hospital should PMVA related PPE be introduced and the parallel view expressed that this would breach therapeutic relationships with patients.

Members noted that previous discussions at the Nursing & Allied Health Professions Advisory Committee were held and debated though not agreed. Mr Jenkins advised that he would seek the outcome and final decision made by the NAHPAC through Mr Mark Richards, Director of Nursing, AHP's and Operations. Mr Jenkins advised that he would a position statement to the Forum in May on the peripheral work around this and the default position i.e. Public Order Police.

Action: Mr Gary Jenkins

As Alan Blackwood was not present at today's meeting it was agreed that he would be contacted to see if further input form the clinical forum was required.

Action: Sheila Howitt

NOTED.

12 REVIEW OF EQUALITY OUTCOMES WORKSHOP REPORT FROM MEETING HELD ON 1 FEBRUARY 2021

Sandie Dickson advised the workshop did not go ahead, therefore would be undertaking the process via a series of workshops which have not yet concluded. Members agreed to move this item of discussion and outcomes paper to the meeting in May 2021. Julie Warren agreed to update the workplan.

Action: Sandie Dickson / Julie Warren

NOTED.

13 ADVICE NOTE FROM THE MENTAL WELFARE COMMISSION REGARDING DEPRIVATION OF LIBERTY

Advice Note from the Mental Welfare Commission regarding deprivation of liberty was **received** and **noted**. The Forum recognised that this would tie in with the seclusion and IOP work.

Sandie Dickson raised concern on the completeness of the EQIA filter within the hospitals SBAR and agreed to contact Margaret Smith, Board Secretary to discuss document control and the possibility of providing a guidance note on EQIA and Human Rights processes when producing SBAR's.

Action: Sandie Dickson

NOTED.

14 PREPARATION FOR ANNUAL REPORT 2021-2022 TO TSH BOARD MEETING ON 17 JUNE 2021

The Forum Chair agreed to contact Board Secretary in relation to preparation of the 2021-22 Annual Report to TSH Board.

Action: Sheila Howitt

Sandie Dickson expressed her disappointment that the Minister did not seek views from patients and carers during the 2020 Annual Review. Mr Jenkins advised that comments and views on this observation were not missed, indeed the approach was taken in tow with governance line. Given the emergency footing was extended for a further six-month period, the previous approach would come back in to play after this time following the ceasing of the NHS operating under the emergency footing.

NOTED.

15 REVIEW OF CLINICAL FORUM WORKPLAN

Members **received** and **noted** the Forum Workplan. Members agreed that EQIA outcomes, Annual Report and an update on IOP would move to the May meeting. The work on Triangle of Care was agreed to move from May to July 2021.

Action: Julie Warren

AGREED.

16 ANY OTHER COMPETENT BUSINESS

a) Sandie Dickson advised that a paper to re-establish physical patient visits would be submitted to the Scientific Advisory Group for consideration of recommencing visits week commencing 26 April 2021.

b) Sandie Dickson advised that positively, funding to work on Family Centre garden was approved.

c) Fiona Warrington advised that the second dose of Pfizer vaccine would be administered to high priority patients on 26 March 2021. Clinics for the first dose of AstraZeneca vaccine would run on 29 and 30 March 2021.

NOTED.

17 DATE AND TIME OF NEXT MEETING

The next meeting of the Clinical Forum would take place at 10am on Tuesday 25 May 2021 via Microsoft Teams.

Meeting concluded at 1220 hours.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Reference:	Item No: 12
Author:	Staff Governance Committee Chair
Title of Report:	Staff Governance Committee – Annual Report 2020/21
Purpose of Report:	For approval

1 SITUATION

The attached Staff Governance Committee Annual report outlines the key achievements and key developments overseen by the Committee during 2020/21. 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 2020/21, 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

The Board is asked to approve the Staff Governance Committee Annual Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Governance Committee report to demonstrate it has met its remit
Workforce Implications	No specific implications in this report
Financial Implications	None identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee, Audit Committee Submitted as part of year end reporting.
Risk Assessment (Outline any significant risks and associated mitigation)	Not required as part of reporting
Assessment of Impact on Stakeholder Experience	Considered as part of the committee's remit
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).	No impacts identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE ANNUAL REPORT

1 April 2020 – 31 March 2021

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 2020/21, 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 2020/21 are detailed below.

2. COMMITTEE CHAIR MEMBERS AND ATTENDEES

Committee Chair:
Bill Brackenridge (Chair of Committee, Non Executive Director) [to 31 January 2021]
Pam Radage (Chair of Committee, Non Executive Director) [from 15 January 2021]

Committee Members:
Stuart Currie (part) (Non Executive Director) [from 4 Feb 2021]
Cathy Fallon (part) (Non Executive Director) [from 15 January 2021]
Tom Hair (Employee Director)
Nicholas Johnston (part) (Non Executive Director) [until 31 December 2020]
Brian Moore (Non Executive Director)

In attendance:
Terry Currie (Board Chair) [until 31 December 2020]
Sandra Dunlop (part) (Interim Human Resources Director) [until May 2020]
Gary Jenkins (Chief Executive)
David McConnell (Interim Board Chair) [from 1 January 2021]
Anthony McFarlane (part) (lay member, UNISON) [until Aug 20]
Jacqueline McQueen (lay member, Royal College of Nursing)
Monica Merson (Head of Corporate Planning and Business Support)
Richard Nelson (part) (lay members, Prison Office Association) [from February 2021]
Brian Paterson (Clinical Operations Manager)
Margaret Smith (Board Secretary)
John White (part) (Interim Human Resources Director) [from Aug 2020]

The committee can decide to invite the Board Chair to sit as a member of the committee, for a meeting, should this be required for quorate decision-making.

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 2020/21

During 2020/21 the Staff Governance Committee met on four occasions, in line with its terms of reference (Appendix 1). Meetings were held on:

28 May 2020
20 August 2020
19 November 2020
18 February 2021

4. REPORTS CONSIDERED BY THE COMMITTEE DURING THE YEAR

The Committee received reports and monitored areas as follows:

- Monitoring of Personal Development Planning & Review (PDPR) performance
- Monitoring of Attendance Management performance
- Monitoring HR Performance – Employee Relations Activity
- Values and Behaviours Final Report
- 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 2020
- Corporate Risk Register HD111; Deliberate Leaks of Data
- Workforce Planning
- Staff Engagement to Support Remobilisation Planning
- INWO Independent National Whistleblowing Officer

4.1 ANNUAL REPORTS

Staff Governance Monitoring 2020/21

Instruction was received from the Scottish Government to pause this work due to COVID-19.

iMatter

Members of the committee received the iMatter End of Year Report (2019 cycle) at the May 2020 meeting and were advised that due to Covid-19 the iMatter cycle was paused Nationally.

Members of the committee received further updates at the November 2020 and February 2021 meetings. They were advised of the Everyone Matters Pulse Survey which replaced the annual iMatter survey for 2020. The national report was issued on 4 December 2020, with Boards receiving their own individualised reports. It was recognised that due to Covid-19 the response rates were reduced across all Boards. The Pulse Survey asked 12 questions around well-being and staff experience during the Covid-19 Pandemic.

Occupational Health Service Annual Report

The annual report was presented to the August 2020 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:

- Service Provision – an overview of all services provided
- Key Priorities
- Quality systems, processes and advice
- Key Performance Indicators
- Measures of performance
- Reducing Absence
- Service Level Agreement Renewal

Healthy Working Lives Annual Report

The annual report was presented at the November 2020 meeting, where members of the Committee noted the work of the Healthy Working Lives (HWL) Group and the continued success story in retaining Gold Award status since it was achieved in 2008. There was a delay in submitting the report to the national team due to the pandemic, however this did not prove an obstacle with the Hospital being awarded the Gold Award. In addition, an Employee Wellbeing Survey matching tool was submitted successfully.

The Committee were advised of a new group being established, The Human Resources and Wellbeing Group led by the Interim HRD which reaches a wider staff group from across the organisation. The group provide a Forum to review HR and Wellbeing performance, approve TSH implementation of National Terms and Conditions and Programmes of Work to enhance Employee Wellbeing.

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
- Staff Engagement to Support Remobilisation Planning

PDPR, Personal Development Plan

Monitoring of completion rates for the Personal Development Planning & Review process was kept under scrutiny throughout the year and reported regularly to the Corporate Management Team and Partnership Forum. The average monthly completion rate for 2020/21 was 80.5% - a reduction of 5.4% when compared to the previous year. The reduction was due primarily to the impact of the coronavirus pandemic on the PDPR process and associated compliance. Factors such as staff absence and homeworking made it difficult in some cases to progress appraisals that were due or overdue. Incremental improvements in compliance were achieved, however, from January to March 2021 and the compliance level at 31 March 2021 was 85.3%.

Attendance Management

Although the State Hospitals Board for Scotland did not achieve the absence management target of 5% in 2020/21, the end of year average monthly absence percentage was 5.89%.

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.

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.

Staff Engagement to Support Remobilisation Planning

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 took place across The State Hospital. Patient, career and volunteer feedback was also sought through a series of discussions. The staff engagement activity proved an opportunity to 'check in' with staff and understand their experience of the recent changes. Staff engagement processes targeted specific groups such as RMO's and clinical leaders as well as engaged staff from all levels and departments across the site. Over 250 staff members engaged in responding to questionnaire, teleconference calls, MS team meetings, 1:1 discussions and group response activities.

The challenges presented to the organisation through the Covid-19 pandemic have been recognised however cautious steps are still being taken to move forward into the recovery stage. Allowing various improvements to begin to ensure the Hospital work collectively and become stronger as the transition begins into a revised structure for wider business.

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.

Values and Behaviours Group

A final report was provided to the Committee due to this group being absorbed into the new Culture, Values, Behaviours and Leadership workstream which forms part of the clinical model project reporting directly into the Clinical Model Oversight Board. Key achievements included, iMatter; Staff Recognition; Long Service Awards and 'You've Been Mugged' an initiative that was well received by staff - Recipients received a mug filled with surprise treats that then circulated from person to person anonymously. This told the recipient how much they are appreciated and valued.

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 HWL Group's mission is to provide a forum where health, safety and wellbeing issues can be identified, and strategies put in place to create improvements that result in a happier, healthier and more highly engaged workforce. The group's aim is to improve the health, safety and wellbeing of all our employees, particularly in the following areas: supporting mental health awareness and education, improving physical health and promoting links / networking within and outside of the organisation.

This year, submission for the Gold Award took place later than usual due to current constraints arising from the pandemic. However, this was not an obstacle and The State Hospital was again awarded the Gold Award. In addition, an Employee Wellbeing Survey matching tool was submitted successfully.

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 received 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.

A broad range of control measures are now in place and embedded within routine organisational systems and procedures to reduce the risk of future data leaks. In line with organisational requirements, the risk assessment will be reviewed on a quarterly basis and following any incidents involving deliberate leaks, and will be updated/amended as required. Bi-annual update reports will be provided to the Committee for information.

Notes of Minutes from other meetings

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

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

5. CONCLUSION

The performance year 2020/21 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 2020/21**.**

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

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 Committee can invite the Board Chair to be a member of the committee for the purposes of a meeting, should it be the case that the committee would otherwise be inquorate.

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, once approved, submitted at the next Board meeting. A personal assistant is responsible for minute taking arrangements.

The minutes and action list of the Staff Governance Committee will be presented to the next Staff Governance Committee meeting to ensure actions have been followed up.

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 Local Delivery 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.

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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Reference:	Item No: 13
Author:	Remuneration Committee Chair
Title of Report:	Remuneration Committee Annual Report – 2020/21
Purpose of Report:	For approval

1 SITUATION

The attached Remuneration Committee Annual Report outlines the workplan overseen by the Committee during 2020/21. 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 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.

3 ASSESSMENT

In the performance year 2020/21, 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.

4 RECOMMENDATION

The Board is asked to approve the Remuneration Committee Annual Report.

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Reporting to demonstrate that committee has met its remit
Workforce Implications	No specific proposal to consider
Financial Implications	None Identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Remuneration Committee Submitted as part of year end reporting.
Risk Assessment (Outline any significant risks and associated mitigation)	Not required for reporting
Assessment of Impact on Stakeholder Experience	Not required for reporting
Equality Impact Assessment	Not required for reporting
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE ANNUAL REPORT

1 April 2020 – 31 March 2021

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:

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- 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 2020/21, 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 (to 31 December 2020)
David McConnell, Interim NHS Board Chair (from 1 January 2021)

Committee Members:
Bill Brackenridge, Non-Executive Director (to 31 January 2021)
Stuart Currie, Non-Executive Director (from 4 February 2020)
Cathy Fallon, Non-Executive Director (from 15 January 2021)
Tom Hair, Employee Director
Nicholas Johnston, Non-Executive Director (to 31 December 2020)
David McConnell, Non-Executive Director (to 31 December 2020)
Brian Moore, Non-Executive Director
Pam Radage, Non-Executive Director (from 15 January 2020)

In Attendance:
Gary Jenkins, Chief Executive
Sandra Dunlop, Interim HR Director (part year)
John White, Interim HR Director (part year)
Margaret Smith, Board Secretary

3 MEETINGS DURING 2020/21

During 2020/21 the Remuneration Committee met on three occasions, in line with its terms of reference. Meetings were held on:

- 18 June 2020
- 22 October 2020
- 25 February 2021

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 2019-20.
- 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 2020/21*.
- Consultants discretionary points were reported on and approved.
- Approval of Executive and Senior Managers Pay for 2019-20.

* Agreement of the Executive Directors Performance Planning and Review (Objectives) for the year 2020/21 was delayed due to the Covid 19 Pandemic.

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

5 CONCLUSION

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

I would like to thank the Committee members for their contribution to the meetings in 2020/21.

David McConnell
REMUNERATION COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Remuneration Committee

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE

TERMS OF REFERENCE

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

In addition, there will be in attendance (in full or part):

- 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 Reporting, 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

Date of Meeting:	17 June 2021
Agenda Reference:	Item No: 14
Sponsoring Director:	Director of HR and Wellbeing
Author(s):	Head of Human Resources
Title of Report:	Attendance Performance Summary
Purpose of Report:	For Noting

1 SITUATION

This report provides information on sickness absence within the State Hospital for the period up to 31 March 2021. It should be noted that this update is the board level performance summary, a further level of detail is provided within the Staff Governance Committee attendance report (Quarterly) which is also reviewed by the Human Resources and Well-Being group and Corporate Management Team (both monthly).

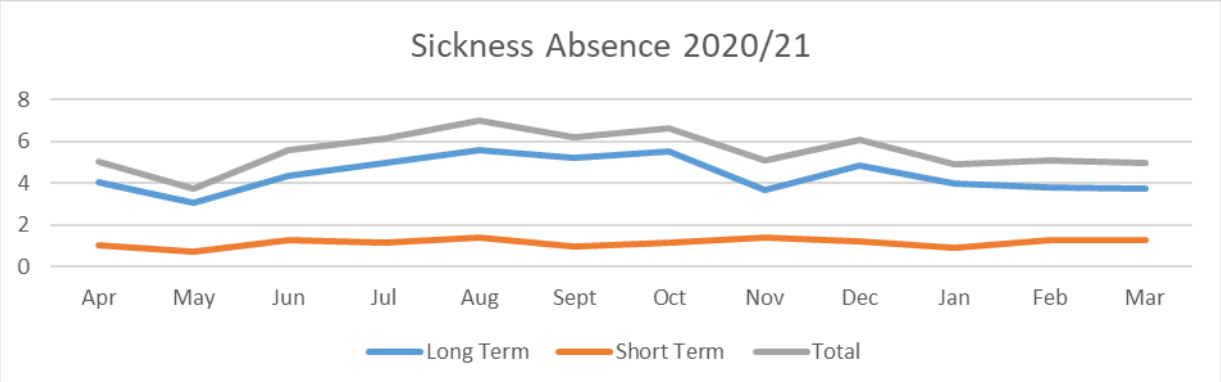
2 BACKGROUND

The State Hospital is required to achieve a sickness absence rate no higher than 5%. The data used is extracted from, SWISS (the national repository) and SSTS (the Board time recording system).

3 ASSESSMENT

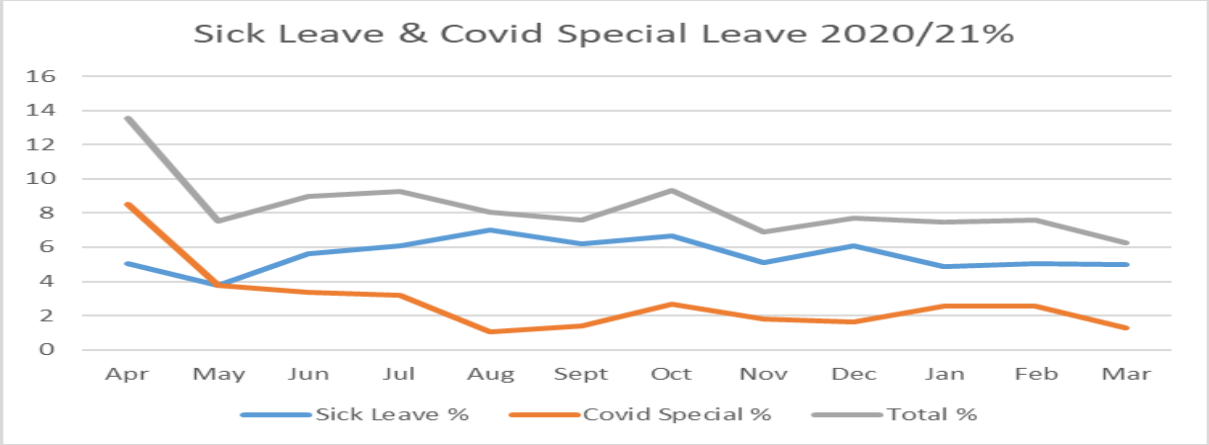
The sickness absence figure from 1 March 2021 to 31 March 2021 is 4.98% with the long/short term split being 3.72% and 1.26% respectively.

Table 1 2020/21 Performance



Long Term	4.05	3.03	4.34	4.98	5.57	5.2	5.54	3.69	4.85	3.98	3.78	3.72
Short Term	1	0.72	1.27	1.13	1.42	0.97	1.12	1.39	1.21	0.92	1.28	1.26
Total	5.05	3.75	5.61	6.11	6.99	6.17	6.66	5.08	6.06	4.9	5.06	4.98

Table 2 Combined sickness absence and COVID-19 related special leave



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Sick Leave %	5.05	3.75	5.61	6.11	6.99	6.17	6.66	5.08	6.06	4.89	5.06	4.98
Covid Special %	8.5	3.75	3.39	3.17	1.06	1.42	2.68	1.81	1.62	2.56	2.53	1.26
Total %	13.55	7.5	9	9.28	8.05	7.59	9.34	6.89	7.68	7.45	7.59	6.24

Table 3 National Performance Comparator

	Total	Long Term [1]	Short Term
Scotland	**4.51**	**3.07**	**1.43**
NHS Ayrshire & Arran	4.20	2.98	1.23
NHS Borders	4.69	3.14	1.55
NHS National Services Scotland [4]	3.39	2.40	0.99
NHS 24	7.90	4.81	3.09
NHS Education For Scotland	0.78	0.59	0.19
Healthcare Improvement Scotland	2.37	1.55	0.82
Public Health Scotland [4]	2.09	1.08	1.01
Scottish Ambulance Service	5.57	4.13	1.44
The State Hospital	**4.98**	**3.72**	**1.26**
National Waiting Times Centre	4.03	2.44	1.58
NHS Fife	4.40	3.27	1.12
NHS Greater Glasgow & Clyde	5.09	3.59	1.50
NHS Highland	4.29	2.86	1.43
NHS Lanarkshire	5.15	3.81	1.34
NHS Grampian	3.50	2.04	1.46
NHS Orkney	4.26	3.09	1.16
NHS Lothian	4.06	2.48	1.58
NHS Tayside	4.35	2.89	1.46
NHS Forth Valley	5.49	3.94	1.55
NHS Western Isles	4.32	2.85	1.47
NHS Dumfries & Galloway	4.77	3.28	1.49
NHS Shetland	3.24	2.33	0.90

4 RECOMMENDATION

Board members are invited to note the contents of this performance update and confirmation of the wider circulation and review of attendance management information.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Attendance Management Policy and aids monitoring of 5% attendance target set by the Scottish Government
Workforce Implications	Failure to achieve 5% target will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% target results in additional spend to ensure continued safe staffing levels
Route To Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee Partnership Forum, HR and WB Group
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Failure to achieve the 5% target will impact on stakeholder experience
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One **X There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Staff Governance Committee held on Thursday 18 February 2021 at 9.45am via MS Teams, The State Hospital, Carstairs. **SGC(M) 21/01**

Present:

Non-Executive Director	Stuart Currie
Employee Director	Tom Hair
Non-Executive Director	Brian Moore
Non-Executive Director	Pam Radage ***(Chair)***

In attendance:

Training and Professional Development Manager	Sandra Dunlop
Interim Board Chair	David McConnell
Chief Executive	Gary Jenkins
Head of Corporate Planning & Business Support	Monica Merson
RCN Staff-side Representative	Jacqueline McQueen
POA Staff-side Representative	Richard Nelson
Board Secretary	Margaret Smith
Director of HR and Wellbeing	John White
PA to Director of HR and Wellbeing	Rhona Preston (minutes)

(In attendance – part):

Organisational Development Manager	Jean Byrne

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Pam Radage introduced herself and welcomed everyone to the meeting, due to this being her first time chairing the Staff Governance Committee she asked everyone to introduce themselves and then provided a brief introduction about herself. Apologies were noted from Cathy Fallon, Non-Executive Director and Brian Paterson, Clinical Operations Manager.

It was noted that agenda item 8 iMatter Update will be taken prior to item number 5 to allow Jean Byrne to attend another meeting.

2 CONFLICTS OF INTEREST

There were no conflicts of interest raised.

3 MINUTES OF THE PREVIOUS MEETING HELD ON 19 NOVEMBER 2020

The Committee approved the Minutes of the previous meeting held on 19 November 2020 as an accurate record.

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Staff-side Representation
Tom Hair advised that previously there were two staff-side representatives however following discussion and agreement by the Committee this has now increased to three.

Occupational Health – SLA
John White advised that a Short-life Working Group (SLWG) will be established to take forward the work required around securing a new Service Level Agreement following the 12 month extension previously agreed to the current provider. This work will look at the requirements of this service moving forward.

ACTION: J WHITE

Health, Safety and Welfare Committee
Gary Jenkins explained that previously a copy of the minute would be presented for information however he has asked the Chair to provide an overview paper highlighting any important issues relevant to the Staff Governance Committee members. The terms of reference are currently being revised and will be shared with this Committee.

ACTION: G JENKINS

ITEMS FOR DISCUSSION

8 iMATTER UPDATE

Members of the Committee received and noted the iMatter update at February 2021, presented by Jean Byrne, Organisational Development Manager, who summarised the report and advised that normally there would have been a National Survey however due to Covid-19 there was a change which resulted in a shorter Pulse Survey undertaken. It is hoped to re-instate iMatter in the coming year, there are discussions taking place currently around the date this can be expected. All NHS Boards have been asked for their input around the timing.

The national report with results from the Pulse Survey was issued on 4 December 2020. Boards also received individualised reports;

At a national level, the National Well-being Pulse Survey results, qualitative themes, wordles and demographics;
At board level, a board report showing staff responses to 12 questions with staff comments on change plus a second report with more qualitative themes and wordles;
At a directorate level, Well-being Pulse Survey results plus a second report with more qualitative themes and wordless.

All reports can be accessed by directors and should be shared within the directorates.

Due to the pressures of Covid-19 the response rates were reduced across all Boards, the response rate for TSH was 48%, compared to iMatter in 2019 at 79%. This reduction was indicative across all Boards.

The survey asked 12 questions about well-being and staff experience during the Covid-19 pandemic. There were also some questions on staff worries, staff support, the work environment and demographics. It is important to keep in mind that these results relate to how people have fared during the pandemic and are a snapshot in time.

The first four questions centred on wellbeing, with the fourth focussing particularly on levels of anxiety. The national report tells us that Health and Social Care staff score higher for their sense of Worth than for Life Satisfaction or Happiness compared with the general population where scores across measures are more consistent.

Jean Byrne summarised the results received and key themes from the report and advised of comparisons across NHS Scotland. Following a lengthy discussion the next steps were agreed;

The results of the survey will be triangulated with other organisational surveys and data over the past year and the learning fed back before the next iMatter run.

This learning should include an investigation into the discrepancy between what the organisation believes it is doing and what staff perceive as outcomes.

The iMatter Operational Lead should work with team managers to coordinate a response from teams across the organisation and communicate these responses to this group, Healthy Working Lives and the Wellbeing Champion for discussion.

The Healthy Working Lives Group, in collaboration with TSH Health Champion, should agree how to take forward key concerns in this survey.

The organisational response must inform our organisational recovery plan.

Members noted and endorsed the next steps to be undertaken.

STANDING ITEMS

5 ATTENDANCE MANAGEMENT REPORT – DECEMBER 2021

Members of the Committee received and noted the report up to 31 December 2021, as presented by John White, Director of HR and Wellbeing, who advised members that this report is very well signposted through other sources across various meetings. He advised members that the national target is 4% however following recognition of the working environment here the target is 5%.

The reports were summarised advising members that the sickness absence figure from 1 December 2020 to 31 December 2020 is 6.06% with the long/short term split being 4.85% and 1.21% respectively. The total hours lost for this period is 5,766.33 which equates to 35.43 WTE. It was recognised that the December rate reported is the best December figure for 4 years, despite the added Covid pressures.

The monthly absence figure has increased by 0.98% from November 2020 figure of 5.08%. The November 2020 long/short term split was 3.69% and 1.39% respectively.

There is an issue currently with the long-term absence rate however this is remains a main focus in terms of support. The State Hospital are reporting as one of the best Boards in Scotland for the short-term absence rates.

It is anticipated a revised format to this report will be launched during April 2021. The revised version will be shared with members in advance of it being launched, with members asked to provide feedback and comments. The new format will include more timely information from the local source, Scottish Standard Time System (SSTS). Scottish Workforce Information Standard System (SWISS) reporting will also be included to allow the Hospital to complete the National comparison and report to the Workforce Directorate. Members of the Committee will have the opportunity to contribute when the draft report is shared.

Stuart Currie asked John White what success would look like in terms of figures around long-term absence, how would we measure this and how would we know this was going in the right direction at the front-line. He also asked about what is done to support and encourage staff back to work initially in a different department / area.

John White advised that overall success would be achieved when the absence rate was 5% or below and in terms of long-term, the aspiration is to be 3.5% or below. Ensure all staff are supported and have access to the correct support mechanisms. Ongoing engagement with employees, ensure reviews are taking place when they should, intervene at the earliest opportunity. Refer to Occupational Health for support and work with them to reassign staff where possible to allow them to return to work.

Brian Moore referenced a previous meeting and minute and asked further about what has been done to create capacity around case management approach. He also asked about the internal audit work that took place with absence management and what actions came from this. The figures shown in Table 4 of the report indicate that Arran Hub and Cluster have a very low percentage sickness rate compared to the other nursing wards, Brian Moore asked what can be learned from this and their approach.

John White explained that he has held discussions with the key individuals including Kay Japp, Principal Occupational Health Advisor, Contract Manager, SALUS to discuss freeing up time from the PMVA screening process to allow additional work to be carried out around the Case Management (Mental Health) to encourage an increase in the uptake of this service and to enhance the employee management support.

In reference to the query raised around the audit work, John White explained this mainly looked at patterns of absence and the ability to see these from the Return to Works. Work is currently underway with eHealth colleagues who are working on the Tableau system to allow access by all Managers who will have easy direct access to automated reports for their members of staff allowing engagement between manager and staff to discuss any patterns or potential solutions.

The information shown in the report within the Arran Hub is being interrogated further by the HR Advisors.

Richard Nelson acknowledged that John White advised work is ongoing around work-related stress numbers being reported and advised this issue has also been discussed at the HR and Wellbeing Group. He asked if there was any Psychology intervention that could be introduced and referenced that historically this was used, he asked whether this could be re-visited to help reduce the numbers. He also asked if there could be more detail provided around the short-term and long-term absence reasons.

John White explained the Psychology service is purchased via Keil Centre, this is an enhanced service that has been used with positive and effective outcomes. To provide more detail around the absences as suggested John White advised he will need to look at the national report and take advice on whether this information can be interrogated further, if available it can be incorporated into the report.

Staff have previously been supported back into work in different locations if unable to resume to their ‘normal’ area and have undertaken different tasks/duties. It was recognised that with remote working this could further support an earlier return to work. John White reference the recent collaboration with the Disabled Graduate Scheme as a further example of the positive benefits of remote working.

Pam Radage thanked John White for the report and looks forward to receiving the new style of reporting. She thanked everyone involved in reducing the short-term absence, noting this is a reflection on the hard work carried out.

It is recognised that this report is presented to many groups including the Board and Sub committees, therefore Margaret Smith asked for clarification around the routing of this report and where it should be received. There was discussion between the members and agreement that key issues of concern, good practices and changes to practice will be provided in a summarised report for the Board.

6 HR PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

Members of the Committee received and noted the Employee Relations Activity Report to 31 January 2021 as presented by John White, Human Resources Director. John White summarised the report, advising members that during January there were no new cases raised.

Members were updated on some of the reasons associated with the lengthy delays being reported, however John White provided assurance to the Committee that there is an understanding of the people involved behind these cases and that these need to progress in line with policies with a fair approach. It was noted that some of the historic cases will conclude in the next week.

The Committee noted the report and welcomed the assurances given.

7 PERSONAL DEVELOPMENT PLAN REPORT

Members of the Committee received and noted the Personal Development Planning & Review (PDPR) update report, presented by Sandra Dunlop, Training and Professional Development Manager.

As at 31 January 2021 the total number of current reviews was 482 (80.6%), an decrease of 1.5% from 31 October 2020.

- A total of 99 staff (16.6%) have an out-of-date PDPR (i.e. the annual review meeting is overdue) – an increase of 1.7% from 31 October 2020.

- A further 17 staff (2.8%) have not had a PDPR meeting – a decrease of 0.1% from 31 October 2020. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

It was noted that although there is a slight dip in compliance from previous reports in comparison to previous periods / years and other Boards the Hospital are reporting positive compliance figures.

Members noted the impact Covid has and the subsequent challenges from this however they welcomed knowing that meetings are continuing between Manager and Staff member, allowing dialogue between them both and the opportunity to ensure everything is being done to support staff during these ongoing difficult times.

Pam Radage thanked Sandra Dunlop for her report and summary and noted the overall good result and thanked everyone involved.

Members noted the report.

ITEMS FOR DISCUSSION

8 iMATTER UPDATE

As noted earlier.

ITEMS FOR INFORMATION

9 WHISTLEBLOWING

NHSSCOTLAND WHISTLEBLOWING POLICY SOFT LAUNCH

Members received and noted the letter received from the Scottish Government dated 5 February 2021 advising that the implementation date will remain as 1 April 2021, with Boards being asked to continue to work towards this date. Although recognition is given to the service delivery pressures arising from the continuing efforts to provide the best possible care in response to he Covid-19 pandemic, staff must have the confidence to raise any concerns they have, particularly in these unprecedented and challenging times.

WHISTLEBLOWING UPDATE - PRESENTATION

John White provided a presentation outlining the recent communication received from the Scottish Government regarding the introduction of the Independent National Whistleblowing Officer (INWO) for NHS Scotland and the Whistleblowing Standards, that the Scottish Public Services Ombudsman (SPSO) has developed as a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services.

Whistleblowing as a word can sometimes have negative connotations. Whistleblowing is raising a concern or speaking up about issues that have the potential to affect patients, staff and the NHS

itself. Most of the time these concerns can be resolved through conversations with colleagues and managers. However, sometimes things don't get resolved as they should and that's why it is important that there is a process to support people to raise their concern at a higher level.

The Standards apply to anyone who delivers a service on behalf of the NHS. This includes people who work in primary care settings, contractors, volunteers, students and even previous employees. They also apply to anyone who is contracted to provide a service on behalf of the NHS in a private setting or who works alongside NHS staff in a health and social care setting.

Each health board must have a confidential contact – someone who can be approached by anyone, who knows all about how concerns should be handled properly, and can help to make sure the process is done right. There's a similar requirement for confidential contacts to be available to primary care too.

Boards also have Whistleblowing Champions who are non-executive directors employed to ensure that whistleblowing systems are in place and working well. If necessary, the whistleblowing champion can report directly to the Scottish government.

- The Standards provide guidance for people raising concerns and for those receiving them.
- They require organisations to ask what support someone needs when they are raising a concern, and for this to be provided where possible.
- They also introduce new requirements for recording and reporting concerns, to make sure that they are taken seriously at all levels of your organisation.
- The INWO is a new, impartial role, separate to the NHS. The INWO is someone completely independent who can look at how a concern has been handled by the NHS.
- Help is also available from unions, regulatory bodies and Protect (the whistleblowing charity).

The standards will come into effect on 1 April 2021. Work is taking place in the background to ensure The State Hospital is prepared and ready for this launch date. The Corporate Management Team have approved the use of DATIX as the recording system and training plans are underway. Training is available via the Turas platform and Sandra Dunlop and her team are working on ways to add this onto LearnPro.

- The Standards are not meant to be used for every concern raised in the NHS.
- Business as usual processes can be used to resolve concerns including those that meet the definition of whistleblowing.
- Anyone speaking up can ask for their concern to be considered under the Standards, even if a business as usual process exists.
- A discussion needs to take place before escalating a concern to the Standards to check that the concern is eligible.
- Stage 1 concerns usually involve minimal or no investigation and a response should be given within 5 working days.
- Serious concerns and concerns needing investigation should be escalated to stage 2.
- Stage 2 concerns should be responded to within 20 days, however extensions may be required for more complex inquiries.
- After stage 2 you can ask the INWO to review how your concern has been handled and how you have been treated

Anonymous concerns cannot proceed under the Standards and they cannot be brought to the INWO for independent external review. This is because an anonymous concern limits the organisation's ability to carry out an appropriate investigation if they cannot discuss the situation with the person raising they cannot find out all the information needed. Anonymous concerns also limit the legal protections and the organisation's ability to provide feedback and offer support.

It was noted that these standards do not apply to Patients raising a Whistleblowing Concern against the Organisation.

Members were advised that the Confidential Contact for the Hospital is Jacqueline Green, HR Advisor.

It was recognised that the policy development was not been done in Partnership. Tom Hair recommended that staff-side colleagues undertake the training available. John White confirmed this position and assured members that any engagement at the Hospital will be taken forward in partnership.

John white confirmed that work has been taking place and assured members that the Hospital will be ready for the implementation date of 1 April 2021.

Jean Byrne left the meeting.

10 APPROVED MINUTES FROM PARTNERSHIP FORUM FROM 24 NOVEMBER 2020

Members received and noted the approved minute.

11 APPROVED MINUTES FROM HR AND WELLBEING GROUP FROM 12 JANUARY 2021

Members received and noted the approved minute. Pam Radage noted the comprehensive note and took assurance from the content that all areas are being discussed at length.

ANY OTHER COMPETENT BUSINESS

12 ANY OTHER BUSINESS

There was no any other business.

13 DATE AND TIME OF NEXT MEETING

The next meeting will take place on **Thursday 20 May 2021 at 9.45am via MS Teams**.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Reference:	Item: 17
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth / 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 25 March 2021 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 and terminology referencing the Remobilisation Plan.

3.2 Scheme of Delegation

There are no amendments proposed to the Scheme of Delegation, other than updates to reflect / correct up-to-date job titles, directorate change re Security and Risk, and terminology referencing the Remobilisation Plan.

3.3 Standing Orders

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

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 Approved by Board 18 June 2020
17	March 2021	Updated references to Annual Operational Plan – amended to Remobilisation Plan Updated job titles To Audit Committee 25 March 2021

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 EHealth Director ("Finance Director") to:

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

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

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

1.2 Interpretation

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

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

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

1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

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

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

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

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

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

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

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

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

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

1.3.10 The Finance Director is responsible for:

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

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 15

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

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

1. DELEGATION OF POWERS

1.1 Delegation to Committees

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

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

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

2. SCHEME OF DELEGATION TO OFFICERS

2.1 Role of the Chief Executive

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

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

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

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

2.2 Caution over the Use of Delegated Powers

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

2.3 Directors' Ability to Delegate their own Delegated Powers

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

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

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

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

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

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

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

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

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

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

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

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

THE STATE HOSPITALS BOARD FOR SCOTLAND
SCHEME OF DELEGATION

1. Organisational Scope / Profile

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

2. Corporate Governance

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

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

4. Planning and Performance

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

5. Risk Management

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

6. Clinical Governance

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

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
6.5 Complaints				
Responding to complaints	Chief Executive	Deputy Chief Executive	N/A	Complaints guidance
Maintenance of complaints procedures and reporting	Board Secretary	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 http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx and the Scheme of Delegation http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx

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

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

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

8 Execution of Documents

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

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

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

9 Committees

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

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

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

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

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

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

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

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

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Reference:	Item No: 19
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 30 April 2021
Purpose of Report:	For Noting - Update on current financial position

1 SITUATION

The Board is asked to consider the Revenue and Capital Resources spending plans, and monitor financial outturn. This report provides information on the financial performance, which is also issued monthly to Scottish Government (SG) along with the statutory financial reporting template. It is also reported internally to fit in with the new Management Structure.

2 BACKGROUND

Scottish Government are now provided with an annual Operational Plan (formerly LDP) and 3-year financial forecast template, the draft version of which was submitted at the end of February. This process has now been amended by the Board Remobilisation Plan taking the place of the Operational Plan.

TSH have identified six months ongoing funding for Covid-related costs, based on an apportionment of last year's agreed funding. With potential impact of site-access delays on the Perimeter Project, the cost impact of this will be factored as Covid cost to the board in 2021/22.

The base budgets have been established and forecast a breakeven year-end positon, set on achieving £1.249m efficiency savings, as referred to in the table in section 4.

The annual budget of £38.985m is primarily the Scottish Government Revenue Resource Limit allocation, and other anticipated recurring allocations.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The Board is reporting an under spend of £0.125m to 30 April 2021, with the majority of the variance being attributable to vacancy management.

Savings will be realised through the coming months, with unidentified savings also being phased monthly per note 4.

3.2 Key financial pressures / potential benefits.

Office 365
An accrual was set aside March 2021 to help contribute to the anticipated licence costs pressure, this will be monitored with the Head of eHealth and is currently being addressed through NSS's project implementation.

Covid-19
50% of 20/21 funding has been requested for the first six months of this financial year, which will be closely monitored in year, and in regular liaison with SG from the end of Q1.

Clinical Model review
The review of the clinical model identified potential recurring savings in ward nursing - values to be confirmed – which would have been beneficial from early 2020/21. However, this is on hold due to the ongoing Covid crisis and is expected to commence mid-year, possibly September 21.

Travel
Benefits have continued to be recognised due to most meetings and courses now being virtual through the Covid crisis.

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 1	Budget WTE	Actual WTE
Nursing And AHP's	22,111	1,843	1,794	49	400.63	413.53
Security And Facilities	6,453	538	472	65	120.64	117.12
Medical	2,893	241	240	1	21.70	23.76
Chief Exec	1,824	152	143	9	22.07	17.38
Human Resources Directorate	937	78	72	6	14.05	15.07
Finance	2,450	204	208	(4)	29.02	27.27
Cap Charges	2,857	238	229	9	0.00	
Misc Income	(600)	(50)	(75)	25	0.00	0.00
Central Reserves	59	(36)	(2)	(35)	0.00	0.00
	38,985	**3,207**	**3,082**	**125**	**608.11**	**614.13**

Further detail is noted overleaf on first two Directorates – being those with the highest budgets.

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 1	Budget WTE	Actual WTE
Advocacy	148	12	12	0	0.00	
AHPs & Dietetics & SLAs	719	60	42	18	13.33	12.04
Hub & Cluster Admin & Clinical (	1,268	106	89	17	30.10	24.67
NPD & Infection Control & Clin G	443	37	32	5	5.80	4.96
Other	1,337	111	132	(21)	18.50	24.79
PCI & Pastoral	228	19	16	3	3.40	3.60
Skye Centre	1,794	149	124	25	37.33	31.27
Ward Nursing	16,174	1,348	1,346	1	292.17	312.20
	22,111	**1,843**	**1,794**	**49**	**400.63**	**413.53**

Highlights from Nursing & AHPs:-

Ward nursing – overtime equates to WTEs being slightly under establishment currently by around 8.00. Therefore one currently offsets the other with breakeven in month.

Others – vacancy management for many of the departments in the directorate is reflected in the favourable variance. There have been many changes within the Management structure and some change forms are still in progress, so some budgets / actual allocations are not yet fully in sync this month, which will be addressed in the current month.

Security & Facilities

Security And Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 1	Budget WTE	Actual WTE
Other	128	11	0	11	2.00	0.00
Facilities	4,571	381	329	52	78.87	77.82
Security	1,754	146	143	3	39.77	39.30
Perimeter Security	0	0	0	(0)	0.00	0.00
	6,453	**538**	**472**	**65**	**120.64**	**117.12**

Highlights from Security and Facilities:-

There have been many changes within the Management structure and some change forms are still in progress, so some budgets / actual allocations are not yet fully in sync this month, including the movement into this directorate of Risk & Resilience, which will be addressed in the current month.

Other:-

Medical, CE, HR, Finance – No significant issues of note identified in first month.

Capital Charges – Awaiting final forecast for 2021/22, with current budget carried forward from previous year.

Misc. Income – The budget now recognises income for exceptional circumstance patients. There are some delays in certain boards' payment, for which pursuit at senior level and CLO continues.

Central reserves
Savings unidentified are phased as twelfths.

4 ASSESSMENT – SAVINGS

The following table summarises the savings set by Directorate.

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	(26)	0	(26)	0
Nursing & AHP's	(265)	0	(265)	0
Human Resources	(15)	0	(15)	0
Medical	(147)	0	(147)	0
Security & Facilities	(215)	0	(215)	0
Unidentified (phased 1/12ths ytd)	(438)	36	(401)	0
Total	**(1,249)**	**36**	**(1,213)**	**0**

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%; other National boards have non-pay costs ranging from around 80% (NSS, NES) to 30/40%.; and certain boards treat vacancy savings, or a proportion thereof, as recurring savings.

National Boards Contribution

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working.
There continues to be pressure on the collective boards due to the £15m challenge not yet being fully identified
The level which the Board agreed for 2019/20 onwards remains at £0.220m per annum.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for the year is £0.269m

Over and above this is the perimeter fence project allocation, for which this shows Year 2 of 2, and additional funding for which final approval is now awaited amounting to £500k for two specific security-related capital pressures – being the refurbishment of the MSRs and the replacement of the Key Safe system.

CAPITAL CRL 2021/2022 AS AT APRIL 2021	ANNUAL PLAN	YTD PLAN	YTD SPEND	under/ (over)
	£'k	£'k	£'k	£'k
PERIMETER SECURITY				
STANLEY SECURITY SOLUTIONS LTD		224	224	0
TSH STAFFING APR - Mar'22		17	17	0
SENSTAR CORP		28	28	0
PERIMETER SECURITY TOTAL (Yr 1 of 2)	**2,879**	**269**	**269**	**0**
CAPITAL				
IM&T		0	0	0
OTHER		2	2	0
CAPITAL	**269**	**2**	**2**	**0**
Total CRL	**3,148**	**271**	**271**	**0**

6 RECOMMENDATION

Revenue
Year to date position is £0.125m underspend, with breakeven anticipated for the year-end.

Capital
Spend may not be in even twelfths so this table will show planned and matched spend, with breakeven anticipated for the year-end.

The Board are asked to note the content of this report.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Reference:	Item no: 20
Sponsoring Director:	Chief Executive
Author:	Head of Corporate Planning and Business Support Clinical Effectiveness Team Leader Corporate Planning and Risk Project Support Officer
Title of Report:	Performance Report 2020/2021 and Comparative Annual Figures.
Purpose of Report:	To provide KPI data and information on performance management activities.

1 SITUATION

This report presents a high-level summary of organisational performance for the year from 1st April 2020 until 31st March 2021. Trend data is also provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are as follows: Psychological Therapies Waiting Times and Sickness Absence. Additional local Key Performance Indicators (KPIs) are reported to the Board and included in this report. Board planning and performance are monitored by Scottish Government through the Annual Operational Plan for 2020-21 which was submitted to Scottish Government to outline the priority areas of development. Due to the Coronavirus pandemic, this was updated by a Remobilisation Plan submitted to Scottish Government in September, to cover the period September 20 – March 21.

The Board is asked to note that this report covers the unprecedented period of operation due to the Coronavirus pandemic. During this period, an Interim Clinical Operational Policy (ICOP) was introduced in March 2020 to ensure infection prevention and control measures are prioritised. The ICOP is supported by daily and weekly monitoring of key data to review the impact of the care model on the health and well-being of patients. This ensures that variations and trends are identified in a timely fashion and improvements made through multi-disciplinary discussion. The data gathered to inform decision making is listed below:

- Number of assaults/attempted assaults and verbal aggression
- Complaints and feedback
- Safe staffing
- Observation levels and seclusion
- Predictive data re violence and aggression
- Numbers of patients who cannot tolerate care in more isolated model
- Access to fresh air, physical activity and timetable sessions
- Participation in sessional activities such as those delivered by AHPs and Psychology.

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.

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. Services have continued to be delivered however not necessarily in the same way as pre-COVID.

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

The following sections contain the KPI data for 2020/21 and highlight any areas for improvement through a deep dive analysis for KPI's that have missed their targets.

There are two KPI's which have increased this year and moved into a more positive zone, these are:
- Patients will undertake 90 minutes of exercise each week.
- Sickness Absence (National HEAT standard is 4%, local target is 5%).

There are two KPI's which have improved this year although not changing performance zone, these are:
- Patients will have their care and treatment plans reviewed at 6 monthly intervals.
- Patients will have a healthier BMI.

There are four KPI's which have missed their target this year, these are:
- Patients will have their care and treatment plans reviewed at 6 monthly intervals.
- Patients will be engaged in off-hub activity centers during COVID-19.
- Patients will be offered an annual physical health review.
- Patients will have a healthier BMI.

Item	Principles	Performance Indicator	Target	RAG	20/21	19/20	18/19	17/18		LEAD
1	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	**A**	94.40%	91.73%	96.9%	95.4%	*Figure to March each year.*	**LT**
2	8	Patients will be engaged in psychological treatment	85%	**G**	86.74%	87.93%	92.8%	94.4%	*Figure to March each year.*	**MR**
3	8	Patients will be engaged in off-hub activity centres	90%	**-**	-	83%	81.7%	78.7%	*This indicator was closed in June 2020 to accommodate engagement during restrictions.*	**MR**
3.1	8	Patients will be engaged in off-hub activity centres during COVID-19		**A**	83.33%	-	-	-	*Average from 1 July 2020 to 31 March 2021.*	**MR**
4	8	Patients will be offered an annual physical health review.	90%	**R**	56.67%	98.48%	93%	100%	*Figure for Apr 2020 - Mar 2021.*	**LT**
5	8	Patients will undertake 90 minutes of exercise each week (Annual Audit)	80%	**G**	75.00%	60.70%	56.3%	Q4 only 48.7%	*Average figure for April 2020 – March 2021.*	**MR**
6	8	Patients will have a healthier BMI	25%	**R**	10.50%	8.75%	13.7%	15.8%	*Average figure from April 2020 – March 2021.*	**LT**
7	5	Sickness absence (National HEAT standard is 4%)	** 5%	**G**	5.30%	5.92%	8.26	8.52%	*Figure for April 2020 – March 2021.*	**JW**
8	5	Staff have an approved PDR	*80%	**G**	80.58%	86.68%	80.9%	84.7%	*Figure to March 2021.*	**JW**
9	1, 3	Patients transferred/discharged using CPA	100%	**G**	100%	100%	97%	99%	*Figures for April 2020 - March 2021.*	**MR**
10	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	**G**	100%	100%	100%	100%	*Figures for April 2020 - March 2021.*	**LT**
11	1, 3	Patients will commence psychological therapies <18 weeks from referral date	**100%	**G**	97.66%	99.78%	98.5%	100%	*Figure to March 2021.*	**MR**
14	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	**G**	95.35%	97.68%	99%	99.1%	*Figure to March 2021.*	**LT**
15	2, 6, 7, 9	Attendance by all clinical staff at case reviews	See above	**-**	67.40% overall	71.5% overall	65.6% overall	64.2% overall	*Figures for April 2020 – March 2021*	**All Leads**

No 1: Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals

Target: 100%

Data for 2020/21: 94.40%

Performance Zone: Amber

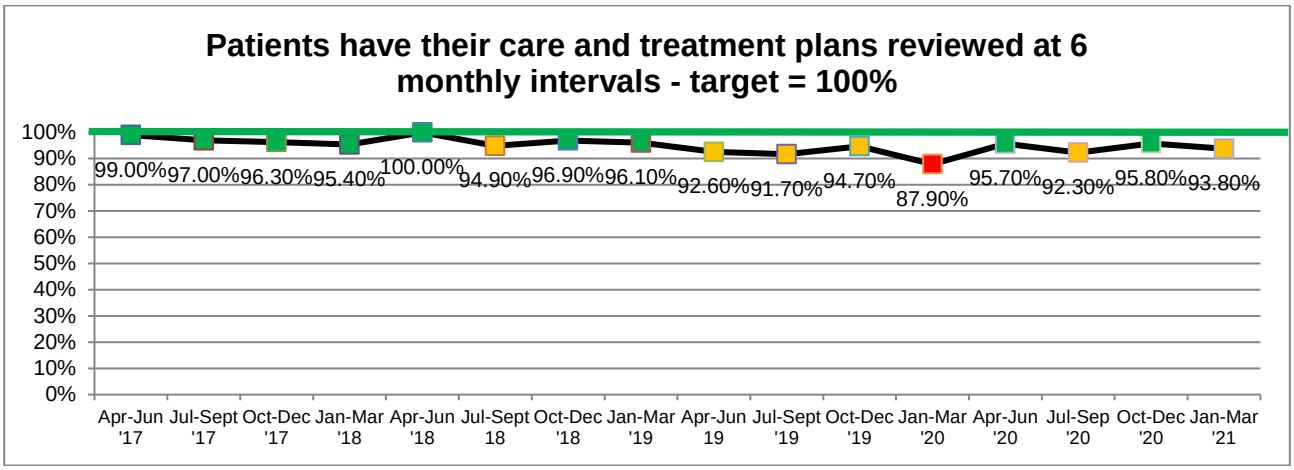
This is a Mental Health Act requirement for any patients within high secure settings. This indicator measures the assurance of patients receiving intermediate and annual case reviews. Care and Treatment Plans are reviewed by the multidisciplinary teams at case reviews and objectives are set for the next 6 months.

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	G	A	G	A	94.40%	91.73%	96.9%	95.4%

Performance has increased in 2020/21 as the figure ending March 2021 was 93.8% compared to 87.9% from the previous year. This indicates that this performance has shifted from the red zone into amber regarding Q4 results. Quarters 1 and 3 were within the green zone and Quarter 2 and 4 were within the amber region; taking the annual average for this indicator to 94.4% and missing the green zone by 0.6%. In addition, the year on year average has increased by 2.67%.

All dates are set in line with the relevant date of an annual review or renewal followed by a 6 monthly review after that. The slight fall in percentage for Quarter 4 can be attributed to changes to the dates of CPA's being held and the overall time taken for documentation to be typed and uploaded to RiO. MHPSG are reviewing the CPA process and this is being governed through Clinical Governance.

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 Treatment

Target: 85%

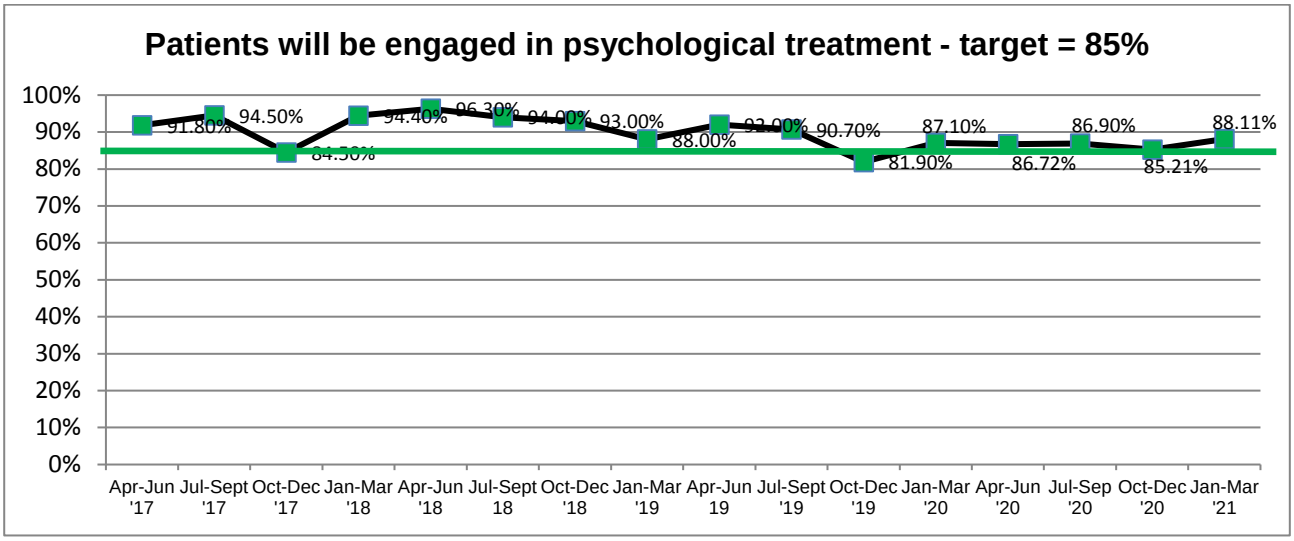
Data for 2020/21: 86.74%

Performance Zone: Green

This indictor is a main priority of National Mental Health Indicators. This indicator measures the percentage of patients who are engaged and involved in psychological treatment.

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Patients will be engaged in psychological treatment	85%	G	G	G	G	86.74%	87.93%	92.8%	94.4%

Performance over the course of the year was above target for all quarters during 2020/21 and the average figure was 86.74%. This is a slight decrease from 2019/20's figure of 87.63%.

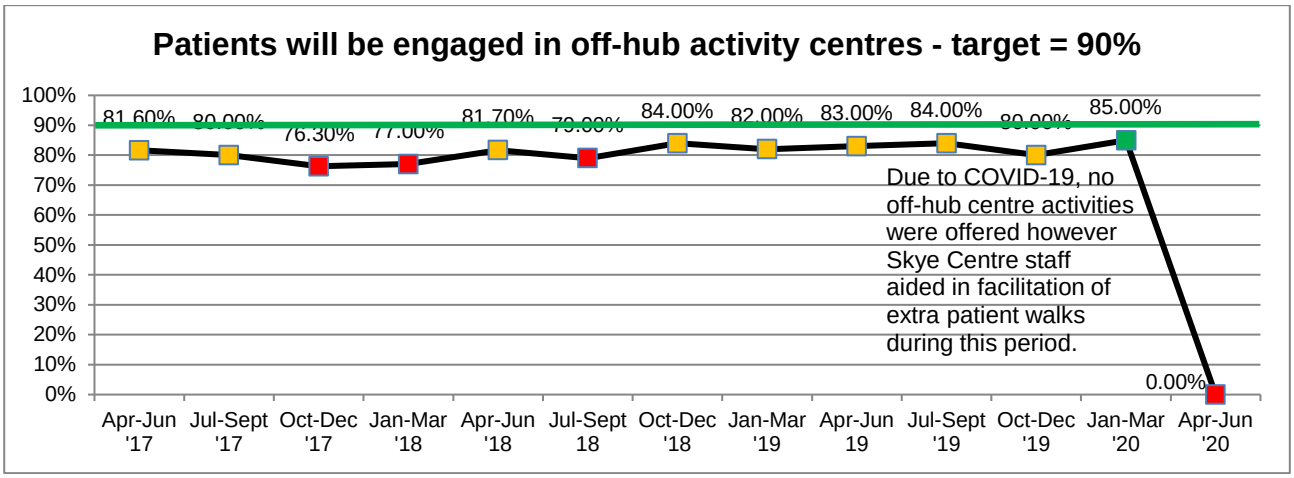


No 3: Patients will be Engaged in Off-Hub Activity Centres

Target: 90%

This is a local priority linking with patient objectives within their care plans and measures the same.

This indicator was closed in June 2020 to accommodate engagement in off hub activity centres during COVID-19.



No 3.1: Patients will be Engaged in Off-Hub Activity Centers during COVID-19

Target: 90%

Data for 2020/21: 83.33%

Performance Zone: Amber

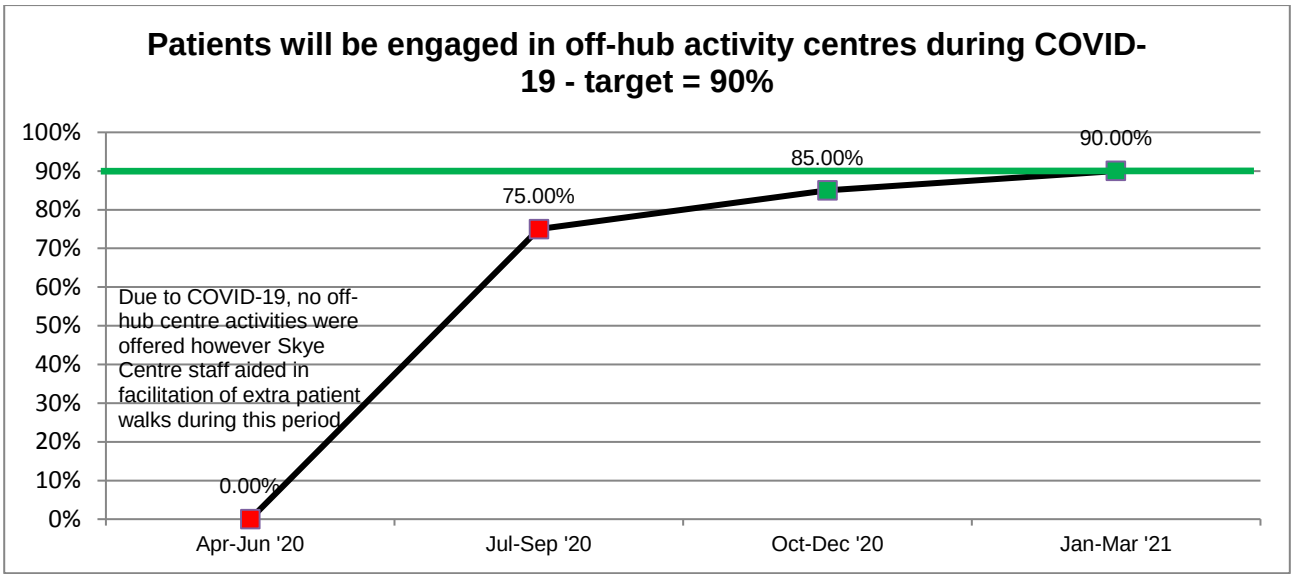
This measures the number of patients who are engaging in some form of timetable activity which takes place off their hub. The sessions may not necessarily directly relate to the objectives in their care plan however recognised as therapeutic activities. This will continue to be reported through the Operating Model Monitoring Group (OMMG).

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Patients will be engaged in off-hub activity centers during COVID-19	90%	-	R	G	G	83.33%	-	-	-

This indicator was adapted from No. 3 to incorporate different modes of engagement during COVID-19. This indicator averaged at 83.33% for this reporting year. As this is an amendment of No. 3, the comparison between this year and the previous year shows a minimal increase of 0.03%.

Due to the COVID-19 pandemic, the recording of patient activity has changed slightly. The e-Health Department and the Skye Centre Secretary are currently adapting the RiO timetables to ensure continued accurate recording, as we did pre-COVID-19, and it is hoped to move back to recording planned activities in the near future. Although we are not recording patients as attending planned activity sessions as we have done previously, patients continue to access off-hub activities through drop-in services.

A weekly timetabling group has been established with members of professional services including Psychology, Skye Centre, Nursing and Occupational Therapy. This group discusses patient activity on a weekly basis, new activities being introduced as well as identifying gaps and staff deficits that could prevent patients participating in activity.



No 4: Patients will be Offered an Annual Physical Health Review

Target: 90%

Data for 2020/21: 56.67%

Performance Zone: Red

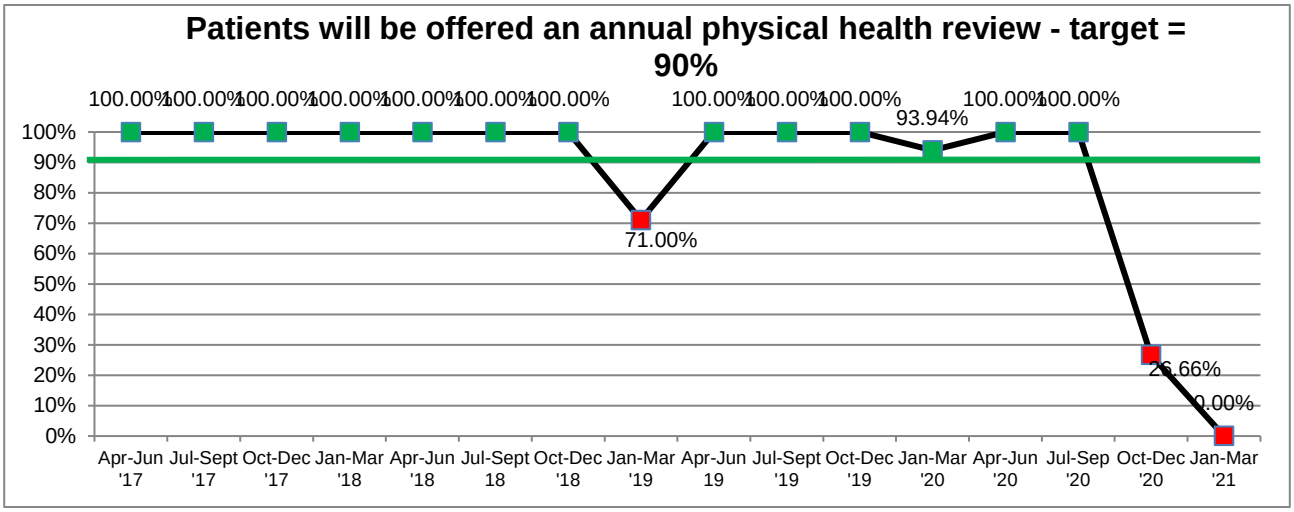
This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS). The indicator currently measures the offer of an annual health review and not the uptake. This is being reviewed to ensure that the KPI accurately captures physical health reviews carried out.

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Patients will be offered an annual physical health review	90%	G	G	R	R	56.67%	98.48%	93%	100%

The overall average during 2020/21 was 56.67%. This is a significant decrease of 41.81% from the year 2019/20 which averaged at 98.48%. Quarters 1 and 2 performed above target with 100% compliance. However, during Q3 and 4, there was significant decreases in compliance with Q3 at 26.66% and Q4 at 0%. This was due to absence of the General Practitioner (GP) due to long term sickness which meant that letters inviting attendance at Annual Health Reviews to see the GP were not issued. It should also be noted that Annual Physical Health Reviews were not carried out in the community at this time due to lockdown restrictions imposed on 26 December 2020.

During Q3 and 4, patients were routinely receiving their annual bloods and ECG assessments in addition to the weekly support offered from the visiting Advanced Nurse Practitioner (ANP) for patients who required more regular assessment and intervention. Any physical health issues with our patients was actioned within 48 hours via the Health Centre and liaison with Junior Doctors during this period has been vital to ensuring that any personal physical issues / needs of our patients are met. In addition, onward outpatient referrals are still being sent through the Health Centre should there be any requirement beyond TSH capabilities, in conjunction with ANP visits. Locum Doctors from the Medwyn Practice were contacted for guidance during this period as the current GP for TSH is absent through long-term sick.

The Health Centre will re-establish the offering of the annual physical health reviews in 2021/22 and discussions are already in place regarding this; albeit in line with Government guidance and restriction levels. Work has progressed regarding the amendment of this KPI to reflect the uptake and quality of the physical health care provided. Moreover, the appointment of the new Practice Nurse will contribute to the KPI accurately reflecting standards in addition to tailoring the KPI to be more results based.



No 5: Patients will be Undertake 90 Minutes of Exercise Each Week

Target: 80%

Data for 2020/21: 75%

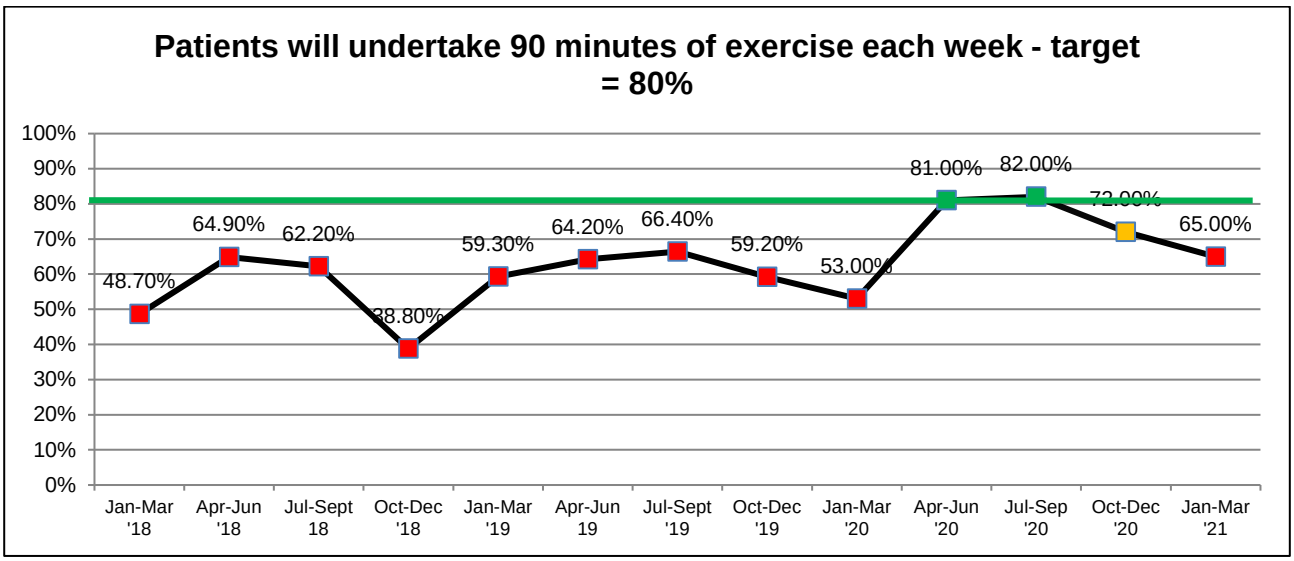
Performance Zone: Green

This links with national activity standards for Scotland. We acknowledge that the national standard is 150 minutes per week however, 90 minutes of exercise was chosen due to this being a challenging target for the hospital with the addition of an obesity issue within the patient group. This measures the number of patients who undertake 90 minutes of exercise each week.

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Patients will undertake 90 minutes of exercise each week	80%	G	G	A	R	75.00%	60.70%	56.3%	Q4 only 48.7%

The target for this indicator is 80% and the overall average for year 20/21 was 75%. This moves this indicator into the green zone for this reporting year, against a red zone performance averaging at 60.7% of 19/20. This is the highest Q4 performance over the four-year trend data provided. The reasons for the improvement in this indicator are being reviewed to support the embedding of these into future practice.

During the first two quarters, staff resources was focused on supporting patients through 1:1 walks as other timetable sessions were cancelled due to COVID restrictions. The COVID-19 pandemic did provide emphasis of physical activity through restrictions which may have led to the positive impact on this indicator. As the Skye Centre Activity Centres reopened, we can see a decline in the physical activity data as patients are engaging in activities not related to any physical means of exercise.



No 6: Patients will have a Healthy BMI

Target: 25%

Data for 2020/21: 10.50%

Performance Zone: Red

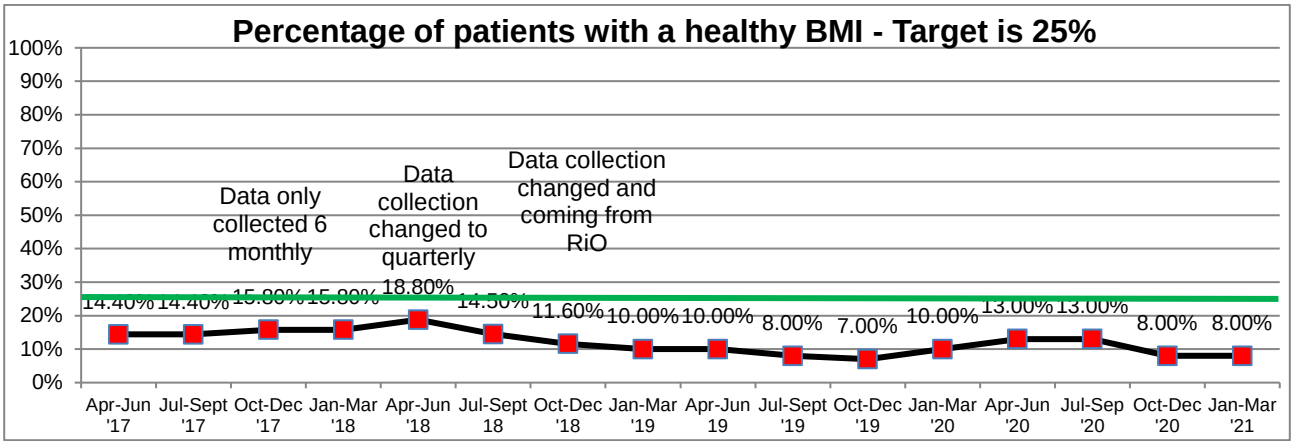
This correlates towards the national target from the care standards as well as a corporate objective of TSH. This is an aspirational target and a local priority due to the obesity issue of our patient group.

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Patients will have a healthier BMI	25%	R	R	R	R	10.50%	8.75%	13.7%	15.8%

The average percentage of patients who have a healthier BMI increased from 8.75% in the previous year to 10.50% in this reporting year. In Q1 there was an increase of 3% from Q4 of the previous year and the figure of 13% was maintained through to Q2. However, there was a decline of 5% in Q3 to 8% and this figure was maintained through to Q4.

The PHSG have requested monthly monitoring reports to review the data and going forward, the Supporting Healthy Choices Group (SHCG) remits to change the culture in TSH for maximising physical activity and promoting healthier lifestyles; including dietary changes where appropriate. The SHCG draft plan of work adopting a Quality Improvement (QI) approach to prevention, reduction and the management of obesity has been submitted to the Board. Options to consider how groups and ward-based weight loss interventions may be delivered have been included within the plan of work. The PHSG has requested monthly monitoring of Shop purchasing to ascertain the percentage of items purchased which fall in the healthy / unhealthy category and devise ways in which we can promote healthier purchases. The patient shop was, however, closed over the year and an ordering system was used which provided more control although, this was not an advantageous move as the number of patients with healthy BMI's did not improve.

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 (National Heat Standard is 4% - Local Standard Is 5%)

Target: 5%

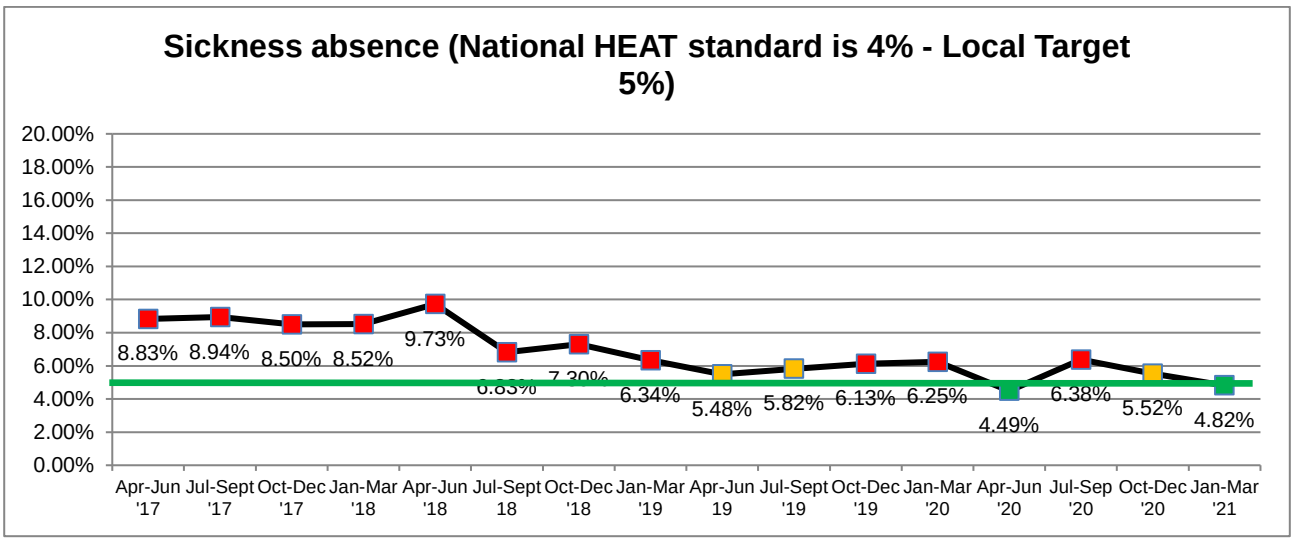
Data for 2020/21: 5.30%

Performance Zone: Green

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Sickness absence rate (National HEAT standard is 4%)	** 5%	G	R	A	G	5.30%	5.92%	8.26	8.52%

In the reporting period 1 April 2020 to 31 March 2021, the rate of absence was 5.30% compared to 5.92% in the previous year - this is a reduction to sickness levels by 0.62%. This is against a 5% target. This moves TSH into the green zone from amber for this reporting year.

It should be noted that in accordance with guidance set out in DL(2020)5 Coronavirus (Covid-19): National Arrangements for NHS Scotland Staff, staff absence and sickness related to Covid-19 is recorded as special leave and does not count towards sickness absence triggers. Details of working hours lost due to COVID-19 related special leave expressed by the monthly totals, are provided below. This ensures that the data comparison is valid for year on year.



No 8: Staff have an Approved PDR

Target: 80%

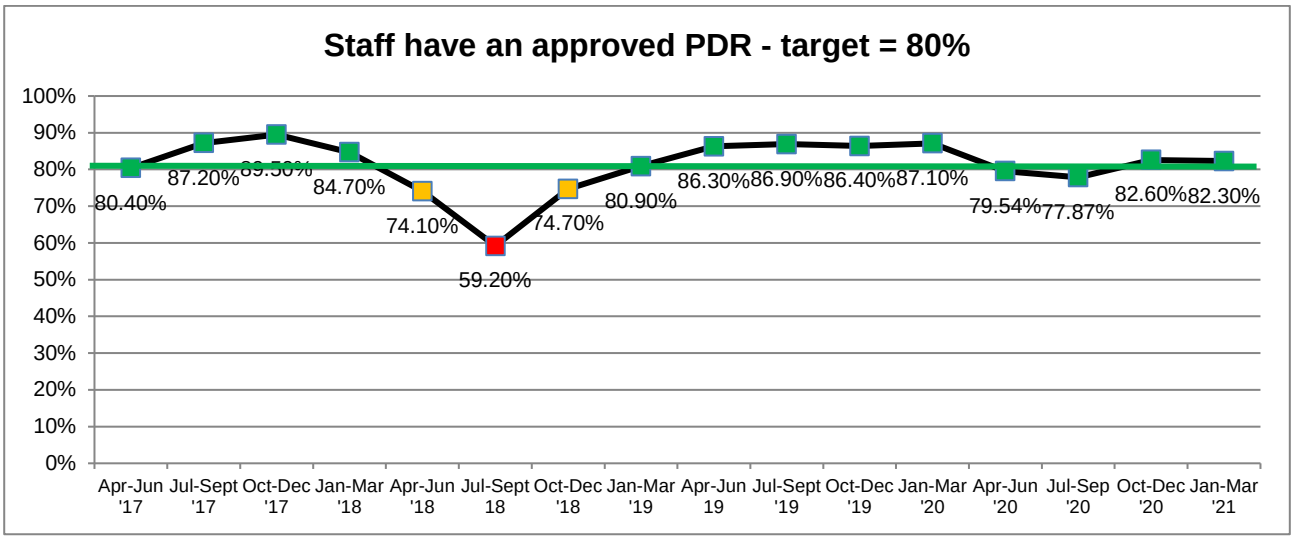
Data for 2020/21: 80.58%

Performance Zone: Green

This indicator relates to the National Workforce Standards; measuring the percentage of staff with a completed PDR within the previous 12 months.

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Staff have an approved PDR	*80%	G	G	G	G	80.58%	86.68%	80.9%	84.7%

The PDR compliance level at 31 March 2021 was 82.30% - the reporting year averaging at 80.58%. This is a slight decrease from the 2019/20 figure of 86.68%. This indicator has consistently been within the green zone since March of 2019. Fluctuations have occurred throughout this time however compliance has been maintained.



No 9: Patients are Transferred/Discharged using CPA

Target: 100%

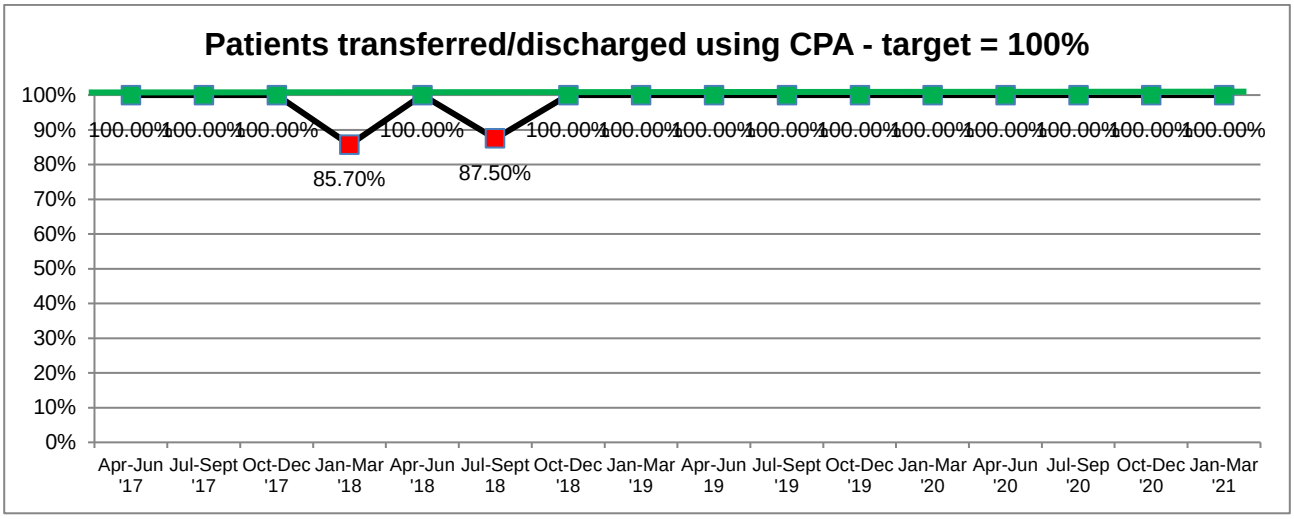
Data for 2020/21: 100%

Performance Zone: Green

The indicator is linked to the Mental Health Act, 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	100%	97%	99%

100% of patients were discharged / transferred using the Care Programme Approach (CPA).



No 10: Patients Requiring Primary Care Services Will Have Access within 48 Hours

Target: 100%

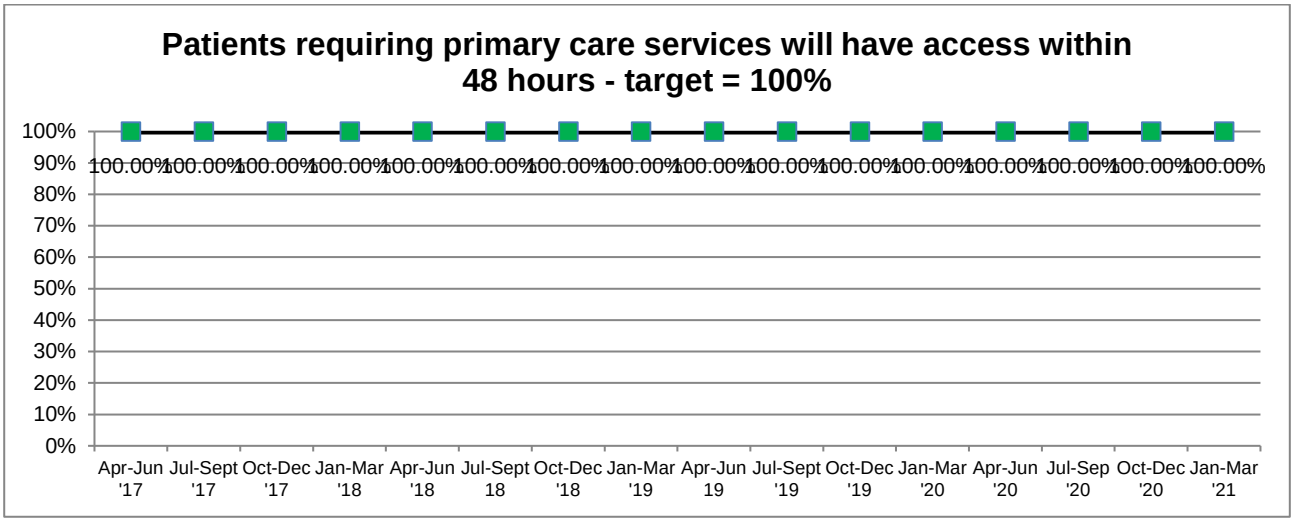
Data for 2020/21: 100%

Performance Zone: Green

This indicator is linked to National Health and Social Care Standards as published by Healthcare improvement Scotland (HIS). Primary care services include any service at our Health Centre including triage.

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	100%	100%	100%

This indicator has consistently stayed at full compliance since its data collection began.



No 11: Patients will Commence Psychological Therapies <18 Weeks from Referral Date

Target: 100%

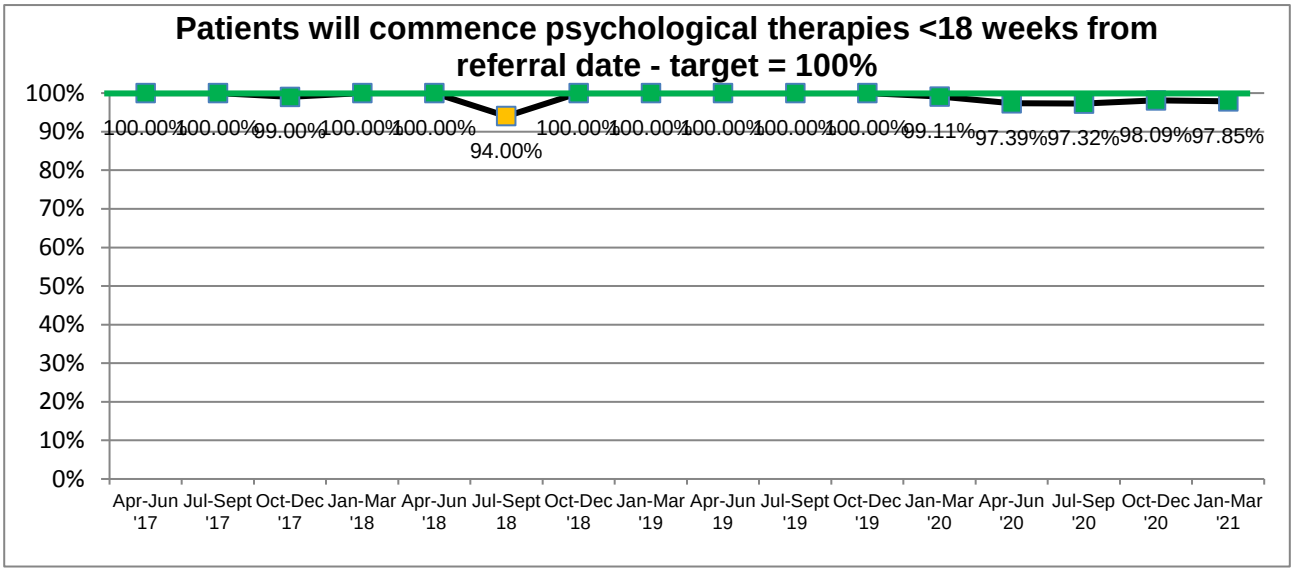
Data for 2020/21: 97.66%

Performance Zone: Green

The indicator correlates to National Mental Health Indicators for Scotland to ensure that no patient waits more than 18 weeks to commence some form of psychological therapy.

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	G	G	97.66%	99.78%	98.5%	100%

There was a slight decrease in this year's figure against 2019/20's figure (2.12%). Compliance was still maintained throughout 2021/21 for this indicator.



No 14: Patients have their Clinical Risk Assessment Reviewed Annually

Target: 100%

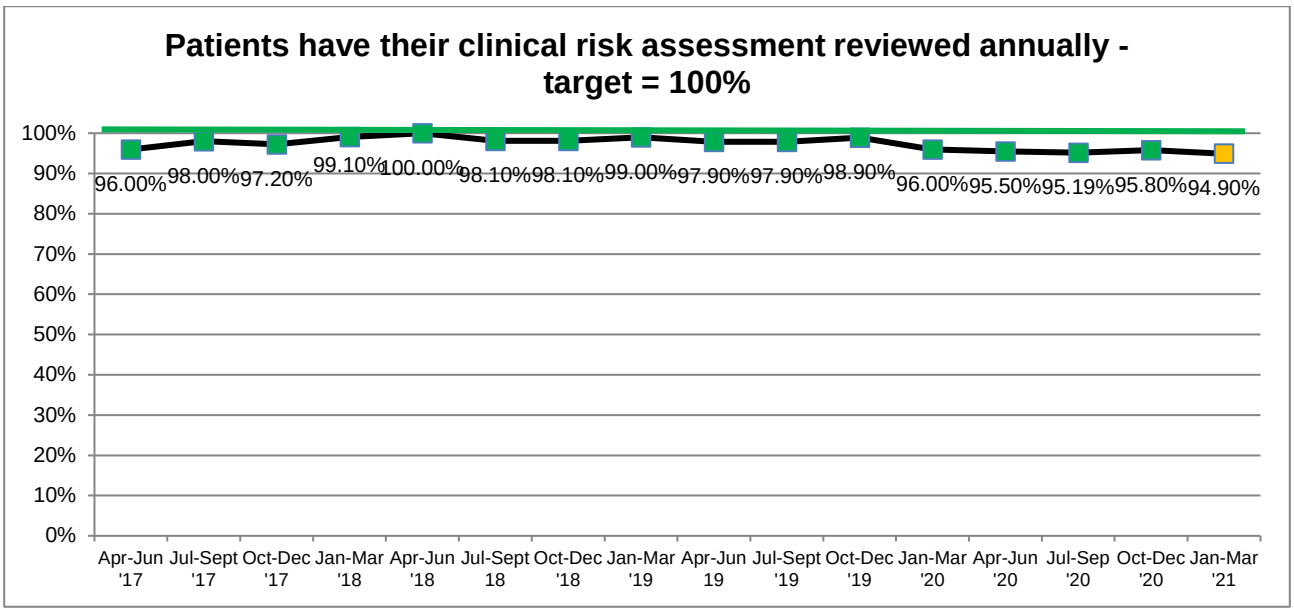
Data for 2020/21: 95.35%

Performance Zone: Green

The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21	19/20	18/19	17/18
Patients have their clinical risk assessment reviewed annually.	100%	G	G	G	A	95.35%	97.68%	99%	99.1%

Performance has remained only slightly below the 100% target throughout the year. The average figure for this indicator in year 20/21 is 95.35% and only during Q4 did we see a move into the amber zone. 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	20/21	Increase/Decrease
RMO	90%	94.8%	90.9%	90%	78.5%	-11.5%
Medical	100%	97.5%	97%	96%	79%	-17%
KW/AW	80%	75.2%	63.6%	78.3%	66%	-12.3%
Nursing	100%	96.5%	96.5%	97.8%	92.3%	-5.5%
OT	80%	65.5%	64.2%	86.3%	77.8%	-8.5%
Pharmacy	60%	57.2%	59.4%	61.3%	63.5%	+2.2%
Clinical Psychologist	80%	70%	84.3%	71.3%	67.8%	-3.5%
Psychology	80%	69.6%	84.5%	87.8%	78.3%	-9.5%
Security	60%	59.8%	41.2%	52.5%	41.8%	-10.7%
Social Work	80%	79.9%	80.8%	73.8%	87%	+13.2%
Dietetics	tbc	3.0%	23.6%	60.8%	77.3%	+16.5%
Skye Centre Activity	tbc	1.0%	1.1%	2.3%	0%	-2.3%
Hospital Wide	**n/a**	**64.2%**	**65.6%**	**71.5%**	**67.4%**	**-4.1%**

RMO – during 2020/21, there was a reduction in RMO attendance at case reviews: the figure reduced by 11.5%. This profession's average moved to the red zone for this reporting year. This can be attributed in part to the new data collection method introduced in response to COVID resulted in discrepancies in completion.

Medical – during 2020/21, there was 17% drop in medical attendance at case reviews. This reduction moves this profession into the red zone for this reporting year. This can be attributed to the two vacancies during the course of the year for this profession.

Key Worker/Associate Worker – there has been a decrease of 12.3% in attendance for 2020/21. This means that they lower into the red zone for this reporting year.

Nursing – attendance from nursing during 2021/21 has dropped by 5.5%. This moved this profession from the green zone into the amber zone for this reporting year.

Occupational Therapy – during 2020/21, attendance from occupational therapy has declined by 8.5% from the previous year. This profession moves into the red zone for this reporting year. This can be attributed to resourcing issues at the beginning of 2020/21 as OT had many vacancies.

Pharmacy – there has been a slight increase in this reporting year of 2.2%. This profession has remained in the green zone for this reporting year.

Clinical Psychologist – there has been a slight decrease of 3.5% attendance for 2020/21. This means that this clinical team have moved from amber zone to the red. This can be attributed in part to the new data collection method introduced in response to COVID resulted in discrepancies in completion.

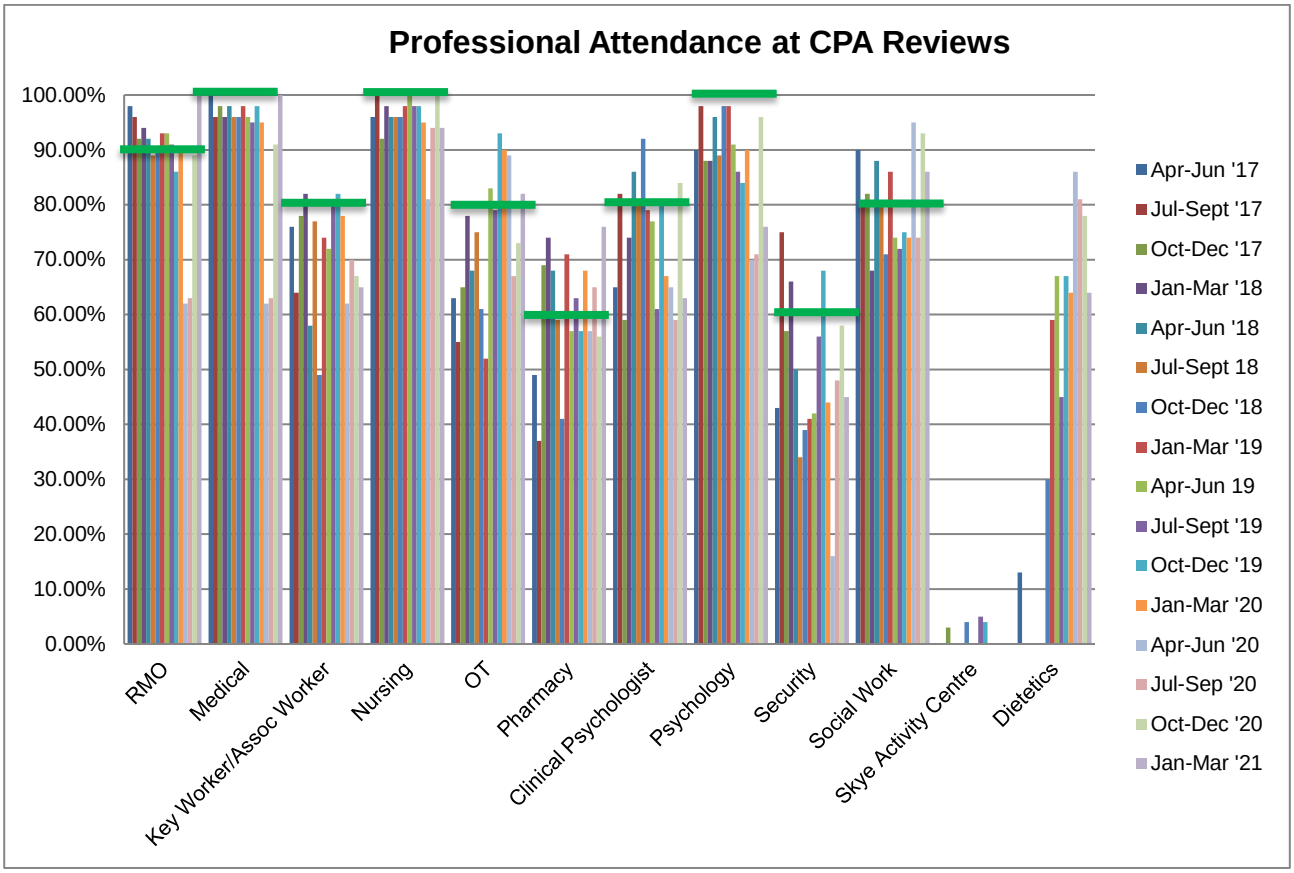
Psychology – during 2020/21, there was a reduction of 9.5% in attendance for this department. This profession remains in the green zone despite this reduction. This can be attributed in part to the new data collection method introduced in response to COVID resulted in discrepancies in completion.

Security – there was a 10.7% decrease in Security attendance during 2020/21. The profession moves from the amber zone into the red for this reporting year. This can be attributed to resourcing issues within security such as annual leave and limited resourcing due to staffing shifts within this department.

Social Work – there has been a 13.2% increase in attendance at case reviews. This moves this profession into the green zone for this reporting year; moving from the amber zone in 2019/20.

Dietetics – during 2020/21, attendance from dietetics has risen again during this reporting year by 16.5%. Dietetics have introduced flexible working to enable access to CPA's from home to contribute to this process. There is no target for this profession as of yet.

Skye Centre Activity – during 2020/21, there was no attendance from Skye Centre staff at case reviews. This figure is a reduction of 2.3% against 20219/20. There is no target for this group 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	The Annual Review of KPI's supports monitoringof corporate objectives
Workforce Implications	n/a
Financial Implications	n/a
Route To Board Which groups were involved in contributing to the paper and recommendations.	CMT
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

Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q3	RAG Q4	Overall attendance Jan – Mar 2021 (n=49)	Overall attendance Oct – Dec 2020 (n=45)	Overall attendance Jul – Sep 2020 (n=46)	Overall attendance Apr - Jun 2020 (n=52)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	G	100%	89%	63%	62%
				Medical **(LT)**	100%	A	G	100%	91%	63%	62%
				Key Worker/Assoc Worker **(MR)**	80%	R	R	65%	67%	70%	62%
				Nursing **(MR)**	100%	G	A	94%	100%	94%	81%
				OT**(MR)**	80%	A	G	82%	73%	67%	89%
				Pharmacy **(LT)**	60%	G	G	76%	56%	65%	57%
				Clinical Psychologist **(JM)**	80%	G	R	63%	84%	59%	65%
				Psychology **(JM)**	100%	G	R	76%	96%	71%	70%
				Security **(DW)**	60%	G	R	45%	58%	48%	16%
				Social Work **(KB)**	80%	G	G	86%	93%	74%	95%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc			0%	0%	0%	0%
				Dietetics **(MR)** (only attend annual reviews)	tbc			64% (n=25%)	78% (n=27)	81% (n=16)	86% (n=21)

APPENDIX 2: QUARTERLY KEY PERFORMANCE INDICATORS FOR 2020-2021

Performance Indicator	Target	RAG Q1 20/21	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	20/21 Average	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	G	A	G	A	94.40%	This indicator remains in the amber zone for 2020/21.
Patients will be engaged in psychological treatment	85%	G	G	G	G	86.74%	This indicator remains green for 2020/21.
Patients will be engaged in off-hub activity centers	90%	R	-	-	-	-	This indicator was closed in June 2020 to accommodate engagement in off-hub activities during the pandemic.
Patients will be engaged in off-hub activity centers during COVID-19	90%		R	G	G	83.33%	This indicator is within the amber zone for 2020/21.
Patients will be offered an annual physical health review	90%	G	G	R	R	56.67%	This indicator moves into the red zone for 2020/21.
Patients will undertake 90 minutes of exercise each week	80%	G	G	A	R	75.00%	This indicator is green for 2020/21.
Patients will have a healthier BMI	25%	R	R	R	R	10.50%	This indicator remains red for 2020/21.
Sickness absence rate (National HEAT standard is 4%)	** 5%	G	R	A	G	5.30%	This indicator is green for 2020/21.
Staff have an approved PDR	*80%	G	G	G	G	80.58%	This indicator remains green for 2020/21.
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	This indicator remains green for 2020/21.
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	This indicator remains green for 2020/21.
Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	G	G	97.66%	This indicator remains green for 2020/21
Patients have their clinical risk assessment reviewed annually.	100%	G	G	G	A	95.35%	This indicator remains green for 2020/21
Attendance at CPA Reviews (Refer to Appendix 1)							

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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Reference:	Item No: 21
Sponsoring Director:	Director of Security, Estates and Resilience
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

1. SITUATION

This report to the Board summarises the current status of the Perimeter Security and Enhanced Internal Security Systems project. Board members are asked to note the overall project update, the financial assessment and current issues under consideration by the Project Oversight Board.

2. BACKGROUND

The Governance for the project is provided by a Project Oversight Board (POB) co-chaired by the Chief Executive and the Director of Security, Estates and Facilities.

The Board meets monthly, with an interim internal meeting taking place between full meetings. The POB last met on 16th June 2021 and is scheduled to meet again on 15th July 2021.

The Programme Director provided an update on the current status on the project and the financial details. The Risk Register was reviewed.

3. ASSESSMENT

a) General Project Update:

This current phase of the project is proceeding according to plan. Cost and quality targets are being met and project timescales have been reviewed and adjusted (See “Project Timescale” at (e) below). A summary of planned and completed works during the period of February 2020 to date include:

b) On-site works Completed:

Item	Completion
Installation and testing of Fibre Network across site	June 2020
Tubestile replacement	July 2020
Installation of CCTV in Skye Centre	July 2020
Installation of CCTV in Arran Hub	October 2020
Installation of CCTV in Mull hub	December 2020
Installation of CCTV in Family Centre	December 2020
Installation of CCTV in Lewis	March 2021
Installation of CCTV in Lewis,1,2 & Hub	June 2021
Moling under perimeter & additional CCTV Columns	May 2021

c) Works underway (adjusted for COVID impact):

Item	Due date
Installation of CCTV in Lewis 3	July 2021
Replacement of Fence detection systems	September 2021
Contingency Gate Airlock works	August 2021
Factory Acceptance Test	June 2021
Car Park CCTV installation	August 2021

d) Offsite works:

Production and review of:

- Detailed design packages
  The project requires 27 Design packages; three have been submitted and are being assessed and 24 have been approved. Two approved packages are currently in commercial assessment to agree additional costs due to the redesign required because of the inaccurate drawing issue previously notified to the Board. (Grounds and patient walkway CCTV and Perimeter CCTV)

- Risk Assessments and Method Statements for all elements of the project. These contain the detailed methodology of how the contractor will approach the task in order to ensure that Health, Safety and TSH requirements are met.

The Factory acceptance test took place week commencing 29th March 2021 and was attended by the Programme Director. Although mostly successful, failures in some minor areas and two critical areas, CCTV control and Personal Attack Alarms, resulted in an overall “fail”. The two critical areas should be addressed in the near future and reassessment is planned for 14th June 2021.

e) Project Timescales:

As previously reported, the project’s planned completion date moved from mid October 2021 to December 2021 due to the impact of COVID, delays on approval of Design Packages and Risk and Method Statements.

A mid programme strategic review has now taken place and Stanley have recast the programme to reflect the outcomes of that meeting, with a revised completion date of 21st February 2022. The revised Contract end date is 13th April 2022. This reflects the previously identified issues and the additional days accrued due to COVID delays (30 days) and the inclusion of the Running Track CCTV (5 days). Additional days will also be accrued due to the changes to the Perimeter CCTV and Grounds and Patient Walkways CCTV design. The number of additional days are under discussion at the time of writing.

f) Finance – Project cost

The project is proceeding according to the current projected cost plan and all quality targets are being met.

The key project outline is:

Project Start Date:	April 2020
Planned Completion Date:	February 2022 (Originally October 2020)
Contract Completion Date:	April 2022 (Originally December 2020)
Main Contractor:	Stanley Security Solutions Limited
Lead Advisor:	ThomsonGray
Programme Director:	Doug Irwin
Total Project Cost Projection (inc. VAT):	£10,346,263
Total costs to date (Inc. VAT):	£ 6,846,884

The expenditure to date is in line with the plan agreed with the contractor, with the schedule planned for the months to come confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our SG funding drawdown is scheduled accordingly. All project payments are processed only once certification is received confirming completion of works to date.

While it is not a prerequisite of the project, regular reports to the SG Capital team are also being provided to notify of progress against total budget.

Spend to Date
Due to the timing of monthly assessments and the production of the Board paper the end of May financial position is not available at the time of writing. There are no issues of concern that are likely to affect the end of May financial position and a verbal update will be available to the Board.

Actual spend to date at 30th April 2021 – in line with Stanley planned schedule of works £ 6.847m

Breakdown of actual spend to date –

Stanley	£ 5.016m
Thomson Gray	£ 0.515m
Doig & Smith	£ 0.007m
VAT	£ 1.107m
Staff Costs	£ 0.202m
	£ 6.847m

4 RECOMMENDATION

That the Board **note** the current status of the Project

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Reference:	Item No: 21
Sponsoring Director:	Director of Security, Estates and Facilities
Author(s):	Programme Director / Director of Security, Estates and Facilities
Title of Report:	Perimeter Security and Enhanced Internal Security Systems: Project Oversight Board Annual Report
Purpose of Report:	For Decision

SITUATION

This paper introduces the Annual Report of the Perimeter Security and Enhanced Internal Security Systems Project Oversight Board. Due to the timing of the project this report covers the period from 1 September 2020 to 31 May 2021. The next report should be a final report in 2022 following completion of the project.

BACKGROUND

The Membership and Terms of Reference of the Project Board were reviewed in the early part of 2020 and the recast Project Oversight Board (POB) has held monthly meetings since that time; the reviewed POB Terms of Reference require the POB to submit an annual report on its activities to the State Hospitals Board. The Terms of Reference state that the annual report 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 POB, including Risk.
- Confirmation that the POB has fulfilled its remit, and of the adequacy and effectiveness of internal control.

ASSESSMENT

The attached Annual report meets the requirements of the POB Terms of Reference

RECOMMENDATION

That the Board note the annual report and approve the suggested annual reporting timescale

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Introduces annual report; no proposal
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Project Oversight Board
Risk Assessment (Outline any significant risks and associated mitigation)	None
Assessment of Impact on Stakeholder Experience	None
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 & ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

PROJECT OVERSIGHT BOARD ANNUAL REPORT

01 September 2020 – 31 May 2021

1 INTRODUCTION

The Report is submitted to meet the requirements within the Project Oversight Board's (the POB) Terms of Reference to submit an annual report of the work of the POB. 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.

Due to the timing of the project this report covers the period from September 2020 to June 2021. The previous paper covered the period from contract agreement on 07 Feb 2020 to the end of August 2020. The final report should be presented in early 2022 following completion of the project and will cover the period from June 2021 to March 2022.

2 THE PROJECT

The history of the project is well known to The Board; following difficulties in procurement of the project, a tender for the required works was awarded in early February 2020 to Stanley Security Systems Limited, who began work on site at the start of April 2020.

3 MEMBERSHIP AND ROLE OF THE "PROJECT OVERSIGHT BOARD FOR THE PERIMETER SECURITY & ENHANCED INTERNAL SECURITY SYSTEMS PROJECT"

Project Oversight Board Membership as at 06 June 2021:

Gary Jenkins:	Chief Executive Officer (Co-Chair)
David Walker:	Director of Security, Estates and Facilities (Co-Chair)
Robin McNaught:	Finance and Performance Management Director
Mark Richards:	Director of Nursing and AHPs
Doug Irwin:	Project Director
Tom Hair:	Employee Director
Bill Sinclair:	Scottish Prison Service (Projects Sponsor)

Support is provided to the Project Oversight Board by Fiona Higgins, PA to the Finance and Performance Management Director and the Director of Security, Estates and Facilities.

Since the last formal review of the Terms of Reference they have been amended to reflect changes to "In Attendance" due to structural changes and the Heads of Security and of Risk are now included; further amendment will take place to reflect the change of Employee Director in due course.

Project Oversight Board Role:

The POB Terms of Reference (Appendix 1) require the POB 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."

3 REVIEW OF THE WORK OF THE COMMITTEE

The POB meets monthly and considers progress reports from the Programme Manager, Project Manager / Lead Advisor and the Contractor. Reports and discussions cover relevant:

- Programme Issues
- Financial Issues
- Quality Issues
- Contractual Issues & contractor performance
- Project Risks
- Change Control

The POB has approved a work plan covering all aspects of the project through to benefits realisation after project conclusion (Appendix 2).

A strategic project risk register is maintained by the Project Manager on behalf of the Programme Director. All risks are reviewed at the monthly internal Operational Team Review Meeting and, if required, risk reduction meetings are called. These may, if necessary, be at short notice in order to deal with any newly arising risks.

The Risk Register is a standing item on the agenda of the Project Oversight Board. At the time of writing two risks are scored as “high” risks; these relate to any increase in costs affecting project affordability and to the impact of COVID19.

An operational Risk Register shared with SSSL is reviewed at each Project Team meeting and any risks identified through that process can, if necessary, be raised for inclusion on the strategic risk register.

Since the previous report the POB has maintained the monthly schedule of meetings required by the Terms of Reference.

4 REPORTING ARRANGEMENTS

The POB reports to each meeting of the State Hospitals Board via a Summary Project Report / Monthly Cost Report by the Security, Estates and Facilities Director. These reports update the State Hospitals Board on all Time, Cost and Quality issues. In addition the POB submits an Annual Report to the State Hospitals Board.

5 PROJECT PROGRESS

5.1 Since contract agreement in February the Contractor has:

Set up a work site at TSH
Recruited a lead subcontractor to supervise delivery
Produced a works programme that includes:

- Procurement
- Surveys
- Risk Assessment and Method Statements for each works package
- Detailed Designs and Design Acceptance for each works package
- Cause and Effect planning
- Works on site
- Factory Acceptance Testing setup, programming testing and delivery
- Site acceptance Testing
- Undertaken various other works on and off site as detailed below:

5.2 Works undertaken & complete on site to date:

- Fibre installation across the site
- CCTV installation in Skye Centre, Arran, Mull, Lewis, Family Visiting and the Tribunal building
- CCTV Installation in Iona Hub, Ward 1 & Ward 2
- Outer perimeter camera column foundations and “moling” to the inner perimeter

5.3 Works to be completed April 2021 to February 2022 commenced but not yet complete:

- Completion of Clinical Area CCTV installation
- Creation of Contingency Gate airlock
- Car Park CCTV installation
- Replacement / refresh of perimeter detection systems

5.4 Works undertaken off site to date:

- Fit out of Factory Acceptance Testing facility
- Installation of equipment
- Programming of equipment
- Factory Acceptance Test (part 1; part 2, scheduled due to some failures, scheduled for 14th June 2021)

5.5 Works to be completed June 2021 to February 2022

- Perimeter CCTV replacement and installation
- Grounds CCTV installation
- Car Park and external are security improvements
    - Automatic Number Plate Recognition
    - Substation detection
    - Reception detection
    - Hostile Vehicle Mitigation

- Painting and civil works to fence
- PAA system upgrade
- Radio system upgrade
- Security Control Room upgrade
- Access Control System upgrade
- Security Management System integration
- Site Acceptance Testing

The progress against the programme is closely monitored by the Project Oversight Board and any issues are raised with the Board in the monthly progress report from the Security, Estates and Facilities

6 CONCLUSION

Based on the work that it has undertaken, the Committee has met in line with its Terms of Reference, has fulfilled its remit and is satisfied that controls are adequate to ensure that the Board can achieve its objectives.

The State Hospitals Board for Scotland

Perimeter Security and Enhanced Internal Security Systems Project

Project Oversight Board - Terms of Reference

1. Purpose

The NHS Board has established a Project Oversight Board to provide the required degree of assurance on the progression of the Perimeter Security and Enhanced Internal Security Systems Project in accordance with the Corporate Objectives of The State Hospitals Board for Scotland, and the appropriate statutory and mandatory standing orders and regulations.

The Project Oversight Board (POB) will provide oversight and assurance, and make recommendations to the NHS Board in line with its remit.

2. Membership

Members:

Gary Jenkins:	Chief Executive Officer (Co-Chair)
David Walker:	Director of Security, Estates and Facilities (Co-Chair)
Robin McNaught:	Finance and Performance Management Director
Mark Richards:	Director of Nursing and AHPs
Doug Irwin:	Project Director
TBC:	Employee Director
Bill Sinclair:	Scottish Prison Service

In Attendance:

Kenny Andress:	Head of Estates and Facilities
Jim Irvine:	Head of Security
Allan Hardy:	Head of Risk

The NHS Board Chair is not a member of the POB, but may attend any meetings of the POB.

3. Reporting Arrangements

The POB will report to the NHS Board following each meeting – this will be through a summary report of the key issues.

The POB will submit an Annual Report to the NHS Board, in June, and this will include: the name of the POB, membership and attendees and officer support, the frequency and dates of meetings, the activities of the POB during the year, any matters of concerns to the POB; confirmation that the POB has fulfilled its remit and of the adequacy and effectiveness of internal controls.

The POB will undertake an Annual Workplan aligned with the Project programme and this will be submitted with the Annual Report.

The POB will undertake an annual review of the Terms of Reference. If this review results in amendment, the revised Terms of reference should be submitted to the NHS Board for endorsement.

4. Key Responsibilities

1. To endorse the scope of the Project, and the benefits to be realised in development, including the clinical service delivery model of the NHS Board.
2. To ensure that the completed facilities are delivered on programme, within budget and are compliant with the NHS Board's corporate objectives and requirements.
3. To ensure that the resources required to deliver the project are available and committed.
4. To ensure appropriate governance through the procurement process and through the Capital Investment Group at Scottish Government.
5. To assure that the project remains within the framework of the overall project strategy, scope, budget and programme as set out in the business case.
6. To review and report changes to the scope of the project e.g. time, cost, quality, to the NHS Board.
7. To promote financial governance and monies and report the adherence within affordability parameter set out by Scottish Government and the NHS Board.
8. To review the risk management plan, ensuring all risks are identified; that appropriate mitigation strategies are actively applied, managed and escalated as necessary, providing assurance to the NHS Board that all risks are being effectively managed.
9. To ensure that staff, partners and service end users are fully engaged in designing operating policies that inform the detailed design and overall procedures that will apply, ensuring that the facilities are service led, not building led.
10. To ensure that communication planning enables the appropriate involvement of and communication with all stakeholders, internal and external, throughout the project.
11. To ensure that appropriate systems of assurance are in place for the functional commissioning of the facilities and operation of the project systems.

5. Conduct of Business

Meetings:

The POB will normally meet monthly. The Co-Chairs may convene additional meetings or change the frequency of meetings as deemed necessary.

The POB may ask any or all of those who attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

The NHS Board may ask the POB to convene further meetings to discuss particular issues on which they want the POB's advice.

Quorum:

A minimum of four members of the POB will be present for the meeting to be deemed quorate.

In the event of a meeting becoming inquorate once convened, the Co-Chairs may elect to continue receiving papers and to allow those present to ask questions and discuss particular matters. The minute should state the point at which the meeting became inquorate but notes of any discussion can be included. Every item discussed and noted in this way will be brought to the next meeting of the POB, under matters arising, for ratification.

Absence of Co-Chairs:
In the event of the Co-Chairs being absent, another member can be designated the chair for the meeting, and this should normally be arranged by the Co-Chairs in advance of the meeting.

Agenda, Papers, Workplan and Minutes:
The POB should have a workplan for the year mapped to the remit of the POB.

The Co-Chairs will set the agenda.

Papers should be submitted to the Project Administrator at least seven working days prior to the meeting. The finalised agenda and papers will be issued to members at least three working days before the date of each meeting.

The meeting will be minuted and will record decisions, actions and responsibilities, actions against identified risks and follow up.

Annual Report:
The POB will prepare and submit an Annual report to the NHS Board in June each year, and this should include:

- The name of the POB, the Co-Chairs, Membership, Executive Leads and Officer supports.
- Frequency, Dates of meetings and attendance.
- The activities of the POB over the year, including confirmation of delivery of the workplan and review of the terms of reference. Should the terms of reference be revised, these should be submitted to the NHS Board for approval.
- Improvements that have been overseen by the POB
- Any areas of concern to the POB, 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 HOSPITALS BOARD FOR SCOTLAND: PROJECT OVERSIGHT BOARD WORKPLAN

AREA OF REVIEW	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021
STANDING ITEMS	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report
FOR INFORMATION	• Lead Advisor Dashboard Report 23 • QS Construction Cost Report 4 • SSSL Progress Report 4 • OTRM 26 Minutes • PT 7 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 24 • QS Construction Cost Report 5 • SSSL Progress Report 5 • OTRM 27 Minutes • PT 8 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 25 • QS Construction Cost Report 6 • SSSL Progress Report 6 • OTRM 28 Minutes • PT 9 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 26 • QS Construction Cost Report 7 • SSSL Progress Report 7 • OTRM 29 Minutes • PT 10 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 27 • QS Construction Cost Report 8 • SSSL Progress Report 8 • OTRM 30 Minutes • PT 11 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 28 • QS Construction Cost Report 9 • SSSL Progress Report 9 • OTRM 31 Minutes • PT 12 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 29 • QS Construction Cost Report 10 • SSSL Progress Report 10 • OTRM 32 Minutes • PT 13 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 30 • QS Construction Cost Report 11 • SSSL Progress Report 11 • OTRM 33 Minutes • PT 14 Minutes • Project Risk Register
MILESTONES:								
COMMISSIONING OF SYSTEMS								
MOVEMENT OF EQUIPMENT								
OTHER ISSUES	Annual Report to TSH Board		Completion of "Cause and Effect" design					

AREA OF REVIEW	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021
STANDING ITEMS	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report
FOR INFORMATION	• Lead Advisor Dashboard Report 31 • QS Construction Cost Report 12 • SSSL Progress Report 12 • OTRM 34 Minutes • PT 15 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 32 • QS Construction Cost Report 13 • SSSL Progress Report 13 • OTRM 35 Minutes • PT 16 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 33 • QS Construction Cost Report 14 • SSSL Progress Report 14 • OTRM 36 Minutes • PT 17 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 34 • QS Construction Cost Report 15 • SSSL Progress Report 15 • OTRM 37 Minutes • PT 18 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 35 • QS Construction Cost Report 16 • SSSL Progress Report 16 • OTRM 38 Minutes • PT 19 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 36 • QS Construction Cost Report 17 • SSSL Progress Report 17 • OTRM 39 Minutes • PT 20 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 38 • QS Construction Cost Report 18 • SSSL Progress Report 18 • OTRM 40 Minutes • PT 21 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 39 • QS Construction Cost Report 19 • SSSL Progress Report 19 • OTRM 41 Minutes • PT 22 Minutes • Project Risk Register
MILESTONES:								
COMMISSIONING OF SYSTEMS	FAT (Failed)		Completion of FAT (Part 2)					
MOVEMENT OF EQUIPMENT	FAT equipment delivery (Iona Cameras, w/c 120421)	FAT equipment delivery (Part 1)	FAT equipment delivery (Part 2)					
OTHER ISSUES		Completion of Design process	Annual Report to TSH Board					

AREA OF REVIEW	December 2021	January 2022	February 2022	March 2022
STANDING ITEMS	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report
FOR INFORMATION	• Lead Advisor Dashboard Report 40 • QS Construction Cost Report 20 • SSSL Progress Report 20 • OTRM 42 Minutes • PT 23 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 41 • QS Construction Cost Report 21 • SSSL Progress Report 21 • OTRM 43 Minutes • PT 24 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 42 • QS Construction Cost Report 22 • SSSL Progress Report 22 • OTRM 44 Minutes • PT 25 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 43 • QS Construction Cost Report 23 • SSSL Progress Report 23 • OTRM 45 Minutes • PT 26 Minutes • Project Risk Register
COMMISSIONING OF SYSTEMS		Site Acceptance Testing	Conclusion of Commissioning	
MOVEMENT OF EQUIPMENT				
OTHER ISSUES			Handover	Annual (Closing) Report to TSH Board tba: Post Project Evaluation / Benefits Evaluation plan

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Audit Committee held on Thursday 25 March 2021 at 9.45am via Microsoft Teams **A(M)21/02**

PRESENT:

Non Executive Director	Stuart Currie
Non Executive Director	Brian Moore ***(Chair)***
Non Executive Director	Pam Radage (Item 4a onwards)

IN ATTENDANCE:

Internal

Interim Board Chair	David McConnell
PA to Director of Finance and eHealth	Fiona Higgins ***(Minutes)***
Chief Executive	Gary Jenkins
Director of Finance and eHealth	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith
Director of Security, Estates and Resilience	David Walker

External

Client Manager, RSMUK	Sue Brookes
Head of Internal Audit, RSMUK	Asam Hussain
Director, Azets	Karen Jones

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Brian Moore chaired the meeting and welcomed those joining.

Apologies for absence were noted from Chris Brown, Azets and Tom Hair, Employee Director.

2 CONFLICTS OF INTEREST

Gary Jenkins advised members that since the last meeting he had accepted the position of Chair of the Managed Service Network for Neuro Surgery and whilst this did not constitute a conflict of interest in terms of the business being discussed members were content to note this new position held by the Hospital Chief Executive.

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 21 January 20201 were amended at page 1, to reflect apologies from Gary Jenkins and 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. Updates were provided as noted below:

Action 8 – Corporate Risk Register – Out of Hours Cover

David Walker advised that Lindsay Thomson, Medical Director had confirmed that onsite medical cover ends at 5pm (Monday to Friday) with Out of Hours Cover through NHS24 commencing at 6pm, there is an internal Hospital oncall medical service available during this period with sufficient resources.

Action 9 – Attendance Management Update
Members noted that the Board approved the removal of the Sickness Absence Update from the Audit Committee workplan.

4a Perimeter Security and Enhanced Internal Security Systems Project
Members received and noted a report on the background and accreditation of D4 Services, the independent advisor to the Perimeter Security and Enhanced Internal Security Systems Project, which was presented by David Walker, Director of Security, Estates and Resilience. The report is provide for information and assurance to the Audit Committee.

Brian Moore advised that as the contract is awarded through Thomson Gray, the Audit Committee are content that this is for the Project Oversight Board to understand any issues and highlight as appropriate to the Hospital Board.

Members noted the background and accreditation of the Independent Advisor.

INTERNAL CONTROL AND CORPORATE GOVERNANCE

5 FRAUD UPDATE

A report was submitted by the Director of Finance and eHealth to provide an update on fraud allegations and notifications received from Counter Fraud Services. From the previous meeting there has been a significant increase in the number of alerts received, as previously these are mostly in connection with the increased reliance on electronic systems during Covid19 working and the potential exposure to scamming.

Members were assured that Hospital staff continue to be alert to scamming emails and guidance and awareness is ongoing through the eHealth department with checks and balances in place to mitigate any risks associated with scam emails.

The fraud allegation highlighted at the previous meeting has been investigated internally and is now closed. One new allegation was received in quarter 3 and this is currently under internal investigation.

The Committee were content to note the detail of the report.

6 FRAUD ACTION PLAN

The Committee received and noted a report which provided an update on Board engagement with Counter Fraud Services (CFS). Robin McNaught advised members that the Annual Review date continues to be deferred until Covid19 restrictions permit. Progress had been made with the introduction of virtual sessions as detailed in the report at Appendix 1.

Robin McNaught assured members that regular contact and communication is held between himself, the Deputy Finance Director and CFS.

Karen Brown assured members that external audit have an increased focus on fraud and have robust testing and processes that lead to identification of fraud or any irregularity for misstatement in the annual accounts with internal controls incorporated into audit work.

Asam Hussan advised that as part of the audit of Accounts Payable and eHealth, internal controls were tested to ensure appropriate mitigations are in place and that a process for checking duplicate or suspicious payments is operable.

The Committee noted the progress on engagement activities; noted the update on Communication; reviewed the updated Fraud Action Plan (Appendix 1) and noted the review of the revision to the Top Ten Risks identified from the FRAM (Appendix 2), as discussed with CFS and FLO on Thursday 24 September 2020.

7 POLICY UPDATE

The Committee received a report on Policies which was prepared by the Clinical Effectiveness Team Leader and presented by the Director of Finance and eHealth. The report advised that since the formation of the Policy Approval Group in September 2020 a total of 14 policies have been reviewed and approved, 10 policies have received extensions to the review dates and 2 policies have received approval for updates. The report provided a detailed breakdown of the 132 policies currently active at the Hospital including status, ownership and dates.

It was noted that there is a considerable impact due to the delays associated with the implementation of the Once for Scotland Programme which includes the majority of the HR Policies. Brian Moore asked if a Local Partnership Agreement was in place at the Hospital and Robin McNaught confirmed that he would speak with John White and circulate an update to the Committee in this regard.

ACTION: ROBIN McNAUGHT

Gary Jenkins advised that a development session is proposed with the Partnership Forum in relation to engagement and the way forward and advised that he would ask for a statement from Tom Hair to be available for the June Audit Committee.

ACTION: GARY JENKINS / TOM HAIR

Members found the report very helpful and asked if there were any challenges in regard to the policy process at the Hospital to which Robin McNaught advised that the Policy Approval Group, which meets monthly and is attended by the Directors as policy owners, works well in ensuring the policy process is complied with, allows a forum for focussed discussion in relation to approvals and extensions and monitoring of policy review compliance.

Members agreed that a 6 monthly update on Policies would be welcomed at the October meeting.

ACTION: ROBIN McNAUGHT

The Committee noted the content of the report.

8 CORPORATE RISK REGISTER UPDATE

The Committee received a paper from the Director of Security, Estates and Resilience which provided an update on the corporate risk register and advised that all risks were in date and a review of both corporate and local risk registers has taken place with work on the local risk registers almost complete and a new process being developed to allow escalation of risks from local to corporate and corporate to local being developed through the Corporate Management Team. There are no new risks which require inclusion.

In relation to the one risk graded as very high, CE14 – Covid19 impact, members noted that this will be subject to further review and possible down grading following the implementation of the vaccination programme, however this will remain subject to continual review.

Gary Jenkins advised that the Board Seminar in May will focus on the process being developed by the Corporate Management Team which should allow for flexibility of moving risks from local to corporate registers and further detail of the process will be provided at the Seminar.

Brian Moore welcomed the opportunity for the Board to discuss the Risk Management Framework in further detail at the Board Seminar in May and members noted the content of the report.

9 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 which was presented by the Director of Security, Estates and Resilience. The report detailed that since the previous report there had been 3 x category 1 reviews, with an additional category 1 review ongoing at the time of drafting the report and 2 x category 2 reviews. An action tracker document provided an overview of all outstanding recommendations including an update for each recommendation. Members noted that David Walker and Gary Jenkins are currently reviewing the process for managing the actions / recommendations with these now being presented fortnightly to the Corporate Management Team for monitoring and a new fortnightly meeting also being held with action owners.

Gary Jenkins provided background information to the new Non Executives on the outstanding actions relating to the Category 1 Review 18/01, to provide assurance that work is ongoing to address and review the recommendations. A design and tender process to address the MSR rooms is complete with funding over a 2 to 3 year period in place with one completed MSR room to in each hub over the first year, this is in line with the new Clinical Model. Discussion and agreement on the use of enhanced PPE is still to be concluded, however robust processes are in place where Public Order through Police Scotland is utilised if required.

Members agreed this was a useful and informative report and noted the current outstanding actions and welcomed the new system for review.

INTERNAL AUDIT

10 AUDIT PROGRESS REPORT 2020/21

The Committee received a report from RSMUK which outlined the progress made against the internal audit plan for 2020/21. Asam Hussain summarised the report noting that the review of Workforce Planning has been moved to the 21/22 audit period as this requires the implementation of the Clinical Model to be in place, that fieldwork is now complete in relation to the Recording of Absence to SSTS with draft report now with Hospital management and fieldwork on the eHealth Strategy Review is expected to complete this week. Both these reports will be presented to the Audit Committee at its June meeting.

The Committee noted the Audit Progress Report

11 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 24 actions, 1 was closed; 4 require more work prior to closing off and 19 remain active.

Stuart Currie commented that the format was helpful and asked that the status column be completed to assure the Committee that the action is achievable and that progress has been made.

ACTION: ASAM HUSSAIN

In relation to the Rostering and Scheduling of Workforce Audit, Gary Jenkins advised that as part of the Board Seminar in May discussions will take place in relation to shift patterns, historically this has been challenging.

The Committee noted the content of the report.

12 DRAFT INTERNAL AUDIT PLAN 2021/22

RSMUK submitted the internal audit plan for 2021/22 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 including the outcome of the Barren Report. Asam Hussain advised that he had met with all Executive Directors in early March to agree the content. It was acknowledged that some areas of the plan may potentially be impacted due to the ongoing Coid19 situation and resulting catch up of business placed on hold, including the Clinical Model and Workforce Review, contact with lead executives for these audits will be maintained to ensure readiness and timings of audits are appropriate. RSMUK confirmed that they would remain flexible and refine the Audit Plan as required.

Gary Jenkins noted a point of clarity in relation to the Perimeter Project and advised that the perimeter fence is not being replaced the work involved is upgrading the security of the perimeter. Asam Hussain advised that he would update the draft plan to reflect this point and ensure that contact is maintained with David Walker in relation to any changes to the timing of the audit that may be required as the project nears completion.

ACTION: ASAM HUSSAIN

Asam Hussain further confirmed that he would ensure health and wellbeing is included within the Effective Rostering and Overtime Management Audit.

ACTION: ASAM HUSSAIN

The Committee noted and agreed the draft Audit Plan for 2021/22.

EXTERNAL AUDIT

13 AUDIT RISK ANALYSIS AND PLAN

Members received the External Audit Annual Plan from Scott Moncrieff in their role as external auditor. Karen Jones advised the Committee that in the context of the current environment all audit work will be undertaken remotely and in line with Scottish Government Guidance on Covid19.

Members noted that Audit Scotland and the Auditor General for Scotland have extended the audit appointment for a further year to avoid disruption during the pandemic.

As with last year an extension has been given to end of September for conclusion of annual accounts, however it is the Hospital's intention to present these to the Committee and the Board in line with the normal timetable in June.

David McConnell commented that this was a comprehensive plan and report and asked for an update on the emphasis of matter regarding asset valuations, which were noted as a general risk last year. Karen Jones advised that they have not yet had an indication on how the valuer intends to report for the period 2020/21. Robin McNaught advised that a valuation exercise is currently underway which should allow a prompt report at the end of March.

The committee noted the report from the external auditor.

[Break for 7 minutes]

STANDING DOCUMENTATION

14 REVIEW OF STANDING DOCUMENTATION

The Committee received a report from the Director of Finance and eHealth 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 in 2020 and there are no amendments proposed.

Removal of reference to seal of Chief Executive Office from the Scheme of Delegation as this is not in existence.

ACTION: ROBIN McNAUGHT

The Committee provided approval for this documentation to be submitted with their recommendation for adoption by the Board to its meeting in June.

15 REVIEW TERMS OF REFERENCE AND CODE OF CONDUCT

The Committee approved the terms of reference and code of conduct as presented by the Director of Finance and eHealth.

The Committee approved the Terms of Reference and Code of Conduct for submission with the Annual Report of the Audit Committee to the Board meeting in June.

16 REVIEW OF ACCOUNTING POLICIES

A report was received from the Director of Finance and eHealth to provide Committee with an update on the current position with regard to Accounting Policies based upon Financial Reporting Manual guidance. One amendment is detailed, section 1.27 – updated valuation of the Hospital's land and property. BNP will undertake this review for the financial year end and this will be reflected in the final draft presented with the annual accounts.

The Committee approved the accounting policies, which take account of the FReM guidance as they apply to the State Hospitals Board for Scotland.

OTHER ISSUES

17 DRAFT GOVERNANCE STATEMENT

Members received a copy of the draft Governance Statement which will form part of the Annual Report and Accounts and is presented to the Committee for comment and review. It was noted that the Hospital is awaiting possible notification of a specific Covid related paragraph which NHS Scotland may require to be included.

Some minor changes to the attendance schedule was noted and Brian Moore suggested the additional of a paragraph at the framework section to indicate the smooth transition of new members to the Board during a period of significant change. Reference to the Person Centred Improvement Annual Report and the Whistleblowing Annual Report to be included in the activity section.

ACTION: ROBIN McNAUGHT

Members agreed it was useful to see this draft in advance of the presentation of the accounts at the June meeting.

18 FINANCE, EHEALTH AND AUDIT GROUP TERMS OF REFERENCE

Members received and noted the approved terms of reference for the Finance, eHealth and Audit Group (formerly the Risk, Finance and Performance Group), membership and remit changes have taken place to reflect the new management structure and director portfolios, this group continues to be chaired by the Director of Finance and eHealth.

Members noted the terms of reference which were presented for information and that they would receive a copy of the minutes going forward to ensure appropriate governance and oversight for the Group.

19 SECURITY, RISK AND RESILIENCE, HEALTH AND SAFETY GROUP DRAFT TERMS OF REFERENCE

Members received and noted the draft terms of reference for the Security, Risk and Resilience, Health and Safety Group, this group is chaired by the Director of Security, Estates and Resilience and reflects the new management structure and director portfolios.

Members noted the terms of reference which were presented for information and that they would receive a copy of the minutes going forward to ensure appropriate governance and oversight for the Group.

20 ANY OTHER BUSINESS

There was no other business.

21 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Thursday 17 June 2021 AT 9.45am via Microsoft Teams

Paper No. 21/ 52

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	17 June 2021
Agenda Reference:	Item No: 24
Sponsoring Director:	Director of Security, Estates and Facilities
Author(s):	Risk Management Facilitator
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

This report provides CMT with an update on the current risk registers.

2 BACKGROUND

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

3 ASSESSMENT

3.1 See appendix a.

All risk assessments are in date. Details of the risks are available in Appendix A and those requiring action plans have them in place.

3.2 Proposed Risks for inclusion on Corporate Risk Register

Nothing to add at this time. A review of both the Corporate Risk Register and Local Risk Registers has taken place. Most recent update is available in Appendix b.

A recommendation from the RSM audit published in March 2019 was that the risk assessments for the Corporate Risk Register did not include assurances that the risk was being managed. Evidence has been sent to RSM, awaiting confirmation that the action can be closed off.

3.3 Medium/High/Very High Graded Risks

The Register currently has 3 HIGH graded risks:

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
MD30 Failure to prevent/mitigate obesity
ND71 Failure to assess and manage the risk of aggression and violence effectively

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
*SD50 Serious Security Incident
SD51 Physical or electronic security failure
SD52 Resilience arrangements that are not fit for purpose
*SD53 Serious security breaches (eg escape, intruder, serious contraband)
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
ND70 Failure to utilise our resources to optimise excellent patient care and experience
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
*FD96 Cyber Security/Data Protection Breach due to computer infection
*FD97 Unmanaged smart telephones' access to The State Hospitals information and systems.
HRD110 Failure to implement and continue to develop the workforce plan
*HRD111 Deliberate leaks of information
HRD112 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

3.4 Risk Updates

FD94 Inadequate Data Centre and FD97 Unmanaged smart telephones' access to The State Hospital information and systems to be reviewed further. After reviewing risks with Head of eHealth the possibility of risks being transferred to Local Risk Register was discussed. Both risks will be followed up at the next review.

MD35 - Non-compliance with FMD Directive is being removed from the Corporate Risk Register as it no longer applies the UK following the EU Exit. This has been approved at the medicines committee and final sign off took place at the next Clinical Governance meeting in May.

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 – CE14 has been reduced to High. It was agreed at CMT that the grading can be reduced due to the publication of the roadmap to the easing of restrictions due to Covid-19.

The Professional Nurse Advisor has been identified to review the Nursing Directorate risks temporarily. The Risk Management Facilitator has scheduled a meeting and the risks will be updated in due course.

3.5 Risk distribution

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain				CE14	
Likely				MD30	
Possible			CE12, SD50, SD54, ND73, FD91, FD93, HRD112	ND71	
Unlikely			MD33, MD35, SD52, SD55, FD90, FD96, HRD110, ND70	MD34, SD56, HR111, SD51	
Rare			FD95, CE13, FD94	MD32, FD97	CE10, CE11, SD53

4 RECOMMENDATION

The Board are invited to note and review the current Corporate Risk Register

MONITORING FORM

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

Appendix A

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	RA	AP	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Chief Executive	01/09/21	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	01/09/21	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	01/09/21	Risk and Resilience Group	Y/Y	N/A	Quarterly	-
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	31/08/21	CMT	Y/Y	N/A	6 monthly	-
Corporate CE 14	ALL	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Major x Unlikely	Minor x Possible	Chief Executive	Chief Executive	14/06/21	CMT	Y/Y		Fortnightly	-
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/07/21	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	28/05/21	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	31/05/21	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	31/05/21	CMT	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	31/05/21	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	01/09/21	Audit Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	01/09/21	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	01/09/21	Audit Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 54	Service/Business Disruption	Climate change impact on the State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Head of Estates and Facilities	01/09/21	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate SD 55	Service/Business Disruption	Negative impact of EU exit on the State Hospital	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Chief Executive	Security Director	01/09/21	CMT	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	01/09/21	Infection Control Committee	Y/Y	N/A	Quarterly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Unlikely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	30/04/21	CMT	Y/Y	Y/Y	Quarterly	Likelihood ↓
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	31/05/21	CMT	Y/Y	Y/Y	Monthly	-
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	30/04/21	PMVA Group and CMT	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	01/09/21	Audit Committee, RF&P Group & CMT	Y/Y	N/A	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure/breach	Moderate x Possible	Moderate x Possible	Minor x Possible	Finance & Performance Director	Head of eHealth	01/09/21	Information Governance Group & CMT	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	01/09/21	CMT	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	01/09/21	CMT/ Risk and Resilience Committee	Y/Y	N/A	Quarterly	Likelihood ↓
Corporate FD 96	Service/Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Rare	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	01/12/21	CMT/Risk and Resilience Committee	Y/Y	N/A	6 Monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Possible	Major x Unlikely	Finance and Performance Director	Head of eHealth	01/09/21	Information Governance Group & CMT	Y/Y	Y/Y	Quarterly	Likelihood ↓
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	Interim HR Director	Interim HR Director	01/09/21	CMT	Y/Y	N/A	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Unlikely	Moderate x Unlikely	Interim HR Director	Interim HR Director	01/09/21	CMT	Y/Y	Y/N	Quarterly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Possible	Major x Rare	Interim HR Director	Training & Professional Development Manager	01/09/21	H&S Committee	Y/Y	N/A	Quarterly	Impact ↓