THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 27 APRIL 2023
at 9.30 am, held by MS Teams
A G E N D A

9.30am			
1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 23 February 2023	For Approval	TSH(M)23/01
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 23/21
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
10 am	**RISK AND RESILIENCE**		
7.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 23/22
8.	**Infection Prevention and Control Report** Report by the Director of Nursing and Operations	For Noting	Paper No. 23/23
9.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 23/24
10.30am	**** BREAK****		
11.15pm	**CLINICAL GOVERNANCE**		
10.	**Volunteer Story** Led by the Director of Nursing and Operations	For Noting	Presentation
11.	**Clinical Model Implementation – Update** Report by the Medical Director	For Noting	Paper No. 23/25
12.	**Quality Assurance and Quality Improvement** Report by the Head of Planning and Performance	For Noting	Paper No. 23/26
13.	**Clinical Forum** - Approved minutes of meeting held 17 January 2023	For Noting	CF(M) 23/01

11.50am	**STAFF GOVERNANCE**		
14.	**Staff Governance Update Report:** Report by the Director of Workforce	For Noting	Paper No. 23/27
15.	**Whistleblowing – Annual Report** Report by the Director of Workforce	For Decision	Paper No. 23/28
12.20pm	**CORPORATE GOVERNANCE**		
16.	**Annual Review of Standing Documentation** - **Standing Financial Instructions and Scheme of Delegation** - **Standing Orders and Code of Conduct** Reports by the Director of Finance and EHealth/ Head of Corporate Governance	For Decision	Paper No. 23/29 Paper No. 23/30
17.	**Finance Report (to 28 February 2023)** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/31
18.	**Network and Information Systems Report** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/32
19.	**Centralised Visiting – Update** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 23/33
20.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 23/34
21.	**Audit Committee:** - Approved minutes – meeting held 26 January 2023 - Chair's Update – meeting held 6 April		AC(M) 23/01 Verbal
22.	**Any Other Business**		Verbal
23.	**Date of next meeting**		Verbal
24.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
25.	**Close of Session and Reflection on Meeting**		Verbal

Estimated end at 1pm

Approved as an accurate record

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 23/01**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 23 February 2023.

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

Chair: Brian Moore

Present:

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

In attendance:

Social Work Mental Health Manager	David Hamilton
Director of Workforce	Linda McGovern
Head of Planning and Performance	Monica Merson
Head of Communications	Caroline McCarron
Head of Corporate Governance	Margaret Smith [Minutes]
Director of Security, Resilience and Estates	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone to the meeting, and apologies were noted from Dr Sheila Howitt (Chair of the Clinical Forum).

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 22 December 2022 were noted to be an accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 22 December 2022.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 23/01) outlining progress on outstanding actions, and were content to note this update. In answer to a query from Ms Radage, it was confirmed that social media promotion of the volunteer service was being taken forward in a considered way so that volunteering could be promoted and allowing the service to be supported.

As a matter arising it was noted that good progress continued to be made towards finalisation of the adaptations required for the sustainable centralised visiting model, and that these were on track for 31 March.

The Board:

1. Noted the updated action list, and confirmed it as being accurate.

5 CHAIR'S REPORT

Mr Moore provided an update to the Board in relation to the main areas of focus and sessions attended since the last Board meeting.

He advised that along with other Non-Executive Directors, he had taken part in a stakeholder event as part of recruitment to the Executive cohort. He had been pleased to be part of the sports charity day, which took place within the hospital on 17 February. There had been cycling and rowing events involving both patients and staff. This had successfully raised monies for the Beatson Cancer Care charity.

Mr Moore welcomed Shalinay Raghavan, Non-Executive Whistleblowing Champion to the Board, noting that there was a paper on the agenda at the meeting updating the position on Board and Committee membership.

It was noted that Mr McConnell had attended the NHS Chairs meetings that had taken place on 30 January. Mr McConnell confirmed that these two meetings had covered a range of issues, and focused on the National Care Service as well as the current systems pressures across NHS Scotland. There had been an update from Professor John Brown, Chair of NHS Greater Glasgow and Clyde, on the roll out of Version 2 of the NHS Scotland Blueprint for Good Governance. The group had received a presentation on the potential impacts on healthcare services from climate change, especially on energy supply and medical gases. The Cabinet Secretary for Health and Social Care had joined the second meeting, and discussion had focussed on systems pressures most particularly within territorial health boards, the Agenda for Change pay negotiations, as well as a future look at the provision of scheduled care and Scotland's population health strategy. There had also been a presentation on developments in the provision of spiritual care led by NHS Tayside, as part of the wellbeing agenda.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

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

He began by noting formally the appointment of Ms McCaffrey to the post of Director of Nursing & Operations for the State Hospital (TSH) following a recruitment process.

Mr Jenkins highlighted the publication of the report from Audit Scotland, NHS Scotland in 2022, and the key messages within the report relating to the recovery of NHS Scotland including to investment as well

as building the workforce through recruitment and retention of staff. The report pointed to the need to be open and transparent about the likelihood of waiting times and the impact of delayed discharges.

He confirmed that Board Chief Executives continued to meet as an Operational Response Group, but that meetings had been stepped down to fortnightly. He provided a summary of the focus Board Chief Executives' regular monthly meetings, including the Agenda for Change pay negotiations and reform process for 2023/24.

Mr Jenkins advised that there was renewed focus on Healthcare in Custody and alignment, including the review of the Deaths in Custody Action Plan. He noted the ongoing work on planning to replace the Violent & Serious Incident Register (VISOR).

He also advised that verbal feedback had been received from the short-life working group, set up nationally, to look at the outcome of the Independent Review into the Delivery of Forensic Mental Health Services (Barron Report). It was intended to move towards a collective leadership model instead of structural changes, and Mr Jenkins noted that Professor Thomson was also closely involved in this through the Forensic Network. Further guidance was awaited from Scottish Government in this regard.

Locally, Mr Jenkins noted that today's agenda included an update of progress of the security re-fresh project, as well as on the implementation of the revised clinical model. He underlined that financial planning and forecasting for expenditure for the year 2023/24 continued to be a priority, and that a further update would come to the Board at its next development session in March 2023.

Mr Jenkins thanked SALUS in respect of their provision of Occupational Health services within TSH and welcomed the new service provision though NHS Dumfries and Galloway.

He noted that the Board, along with senior managers involved, had attended a Health & Social Care Safe Staffing session in January, in advance of the introduction of this legislation, with TSH accepted as an early implementer. Alongside this, progress was being made on implementation of e-rostering within TSH to align with the national schedule, and supported through funding from Scottish Government. Mr Jenkins emphasised that there was a continuing challenge on attendance management, and that target reductions for levels of sickness absence were being closely managed within the context of providing supportive mechanisms for staff to help them return to work.

Following this update, Mr Currie referenced the report from Audit Scotland, NHS Scotland in 2022, noting that whilst there was nothing surprising about the assessment, it did point to the need for innovative ideas to help solve the problems highlighted. He focused on the recruitment and retention of staff, welcoming the centring of the wellbeing agenda, and the need to demonstrate the benefits of this approach through concrete impacts. There was a need for a whole system approach.

Mr Moore noted that the report from Audit Scotland would be added to the Agenda for the Board development session taking place in March, and also that the approach for TSH to the updated Blueprint for Good Governance would be added to the following session.

The Board:

1. Noted the update from the Chief Executive.

RISK AND RESILIENCE

7 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 23/02) from the Director of Security, Resilience and Estates, which provided an overview of the medium, high and very high risks featuring on the Corporate Risk Register. Mr Walker presented an overview of the report for the Board, confirming that all risks rated as 'High" were reviewed monthly by the risk owners and reviews of all risks were up to date. There had been no changes to the grading of any risks or to the risk distribution since the date of the last Board

meeting.

Mr Walker highlighted the continuing work in relation to Risk ND71, relating to the assessment and management of violence and aggression. Level 3 PPE and Bronze commander Training had been completed, Additional support had been provided through the Scottish Prison Service training facility, and an invitation could be extended to Non-Executive Directors to see this at first hand should they wish to do so.

He also advised that further development work was underway within the Risk team to review the register in terms of the governance structure, and to enable flash reports to be produced to help support each governance committee to review the risks within its remit to make this more reactive to any changes in the system.

Ms Fallon welcomed this approach, and asked in particular about the aim of the Short Life Working Group set up in relation to Risk HRD 111 (deliberate leak of information). Ms McGovern advised that this related to a review of information governance training for staff, and to consider any other possible mitigations of this risk. Mr Jenkins echoed the need to review process as being necessary whilst at the same time noting that it may not be possible to eliminate the risk.

Mr Moore summed up by noting the helpfulness of the report, saying that it reinforced the way in which the whole system of risk management had been strengthened and improved, and welcoming the focus of governance committees on the risks within their remit. He noted that it may be timely to review the CE10 Severe Breakdown in Corporate Governance, given the improvements made to strengthen the overall governance arrangements.

Action – Ms Smith/ Mr Jenkins

The Board:

1. The Board reviewed the current Corporate Risk Register and approved it as an accurate statement of risk.
2. Agreed an action for review CE10 relating to governance arrangements.

8 INFECTION PREVENTION AND CONTROL REPORT

The Board received a paper (Paper No. 23/03) from the Director of Nursing and Operations, which provided an update in relation to Infection Prevention and Control (IPC) activity since the date of the last Board meeting. Ms McCaffrey provided a summary of the key points for the Board, highlighting the new structure which was now in place for oversight in this area, and to promote local accountability. This included use of audit tools, and follow up on any areas requiring action. She was able to confirm that during this time period there had been limited impact related to Covid-19 in particular rather than seasonal influenza. She advised that work was continuing to prepare for the inspection programme led by Health Improvement Scotland (HIS) with a self-assessment completed, and actions arising from that being progressed.

Mr Currie commented that there would be a need to ensure that there was confidence that the lessons learnt from the pandemic experience had been learned, and built in to business ad usual practice. In response, Ms McCaffrey concurred with this point, adding that this was the focus of the Infection Prevention and Control Group to ensure that standards were being adhered to at a local level. Mr Moore commented that it would be helpful if the duplication in audit tools and the control book inspections could be re-visited to give alignment, as this would aide a more efficient process and support staff.

The Board:

1. Noted the content of report.

9 BED CAPACITY REPORT

The Board received a paper (Paper No. 23/04) from the Medical Director, which detailed the actions taken to monitor the bed capacity within TSH as well as impacts from the wider Forensic Network.

Professor Thomson summarised the report, highlighting that 14 patients had been fully accepted for transfer; but remained on the transfer list due to major bed capacity issues across the forensic estate. Further, she advised the Board that this was impacting the ability to move patients out of the prison estate. This had been raised at the Inter- Regional Group of the Forensic Network, and would be reviewed in conjunction with colleagues from Scottish Government and the Mental Welfare Commission at a meeting arranged for 7 March 2023.

Professor Thomson advised that TSH remained closed to exceptional circumstances patients, due to the impact of staffing resourcing within the hospital in terms of modified service delivery. However, TSH with 104 patents currently was in a good position in terms of aligning patients with the new clinical model.

In answer to a question from Mr McConnell about the issue raised in respect to HMP Edinburgh, Professor Thomson advised that this had been raised via the Scottish Prison Service and that the relevant NHS Board was therefore NHS Lothian. In terms of TSH, she advised that it should be noted that there were capacity issues within medium secure, but also at a low secure level. If TSH were open to accepting patients under exceptional circumstances, this would be in for patients who were within the prison estate. She noted that it was not within the powers of the Forensic Network to develop planning across the estate, with capacity being within the responsibility of territorial boards. Mr Jenkins added that this should be considered within the context of the lack of medium secure capacity in the overall estate and the obstacles to transferring patients onwards. The long-term plan was to increase the number of available beds within low and medium secure across NHS Scotland.

Mr Currie commented on the risk of patients not being placed within the right level of security, and asked for clarity on the possibility of negative impacts on patient wellbeing of recovery. Professor Thomson advised that there was potential risk of this, and that the excessive security appeals process responded to this. In general terms, the sooner the patient could move to the right level of security, the better for their care. Within the prison estate, there was greater risk as this was not an appropriate setting for a patient assessed for transfer into psychiatric care, and it was not possible to enforce medication when required in this setting. She outlined the referral process within prison settings and how this functioned, as further background.

Mr Moore asked if there was a timescale around the remedial works underway within NHS Lothian medium secure, and this was confirmed as at least 12 months.

It was noted that advice was awaited from Scottish Government on the next steps for the delivery of forensic mental healthcare across NHS Scotland, in terms of a national collective arrangements. Professor Thomson noted that prisoner healthcare had not been included within the previous Barron review, and required further consideration.

On behalf of the Board, Mr Moore thanked Professor Thomson for this detailed and helpful update and noted that the Board would await further progress updates particularly around the ways in which this would impact TSH.

<u>The Board:</u>

1. Noted the content of report.

CLINICAL GOVERNANCE

10 CLINICAL MODEL IMPLEMENTATION

The Board received a paper (Paper No. 23/05) from the Medical Director, to provide an overview of the progress made on the implementation of the revised clinical model. Professor Thomson introduced this paper, noting that a detailed overview had been presented to the Clinical Governance Committee at its meeting this month demonstrating how well advanced implementation was at this point.

Ms Merson then provided a summary of activity to date, highlighting the key project workstreams. At the centre of this was clinical guidance for each service, and bringing these together to give cohesion. This was moving into the stage of final revisions during March. Patient mapping to the appropriate sub-specialty had been completed, and patients had been advised of their placement primarily through their Responsible Medical Officer (RMO) and also with supported provided through the Person Centred Improvement Team as well as the Patient Advocacy Service. Carers had also been contacted to make sure they were fully aware of the planned changes.

Work had also progressed to make sure staff were fully aware and engaged through a further seminar series presentation, and distribution of monthly flash reports through staff bulletins as well as on notice boards across the site. Ms Merson outlined the next steps including development of the service leadership model, with an interim model to be established in the first place. The plan was to commence patient moves during March, as a phased approach to support both patients and staff.

Ms Radage commented on the helpfulness of the report, which demonstrated the good progress of work to date. She asked if the numbers of patients and staff who would be required to move could be detailed, as well as what the settling in period would be and if contingency planning would be required in case of difficulties then arising. Ms Merson advised that 56 patients would move, and that RMO had been very involved in developing tailored plans for patients recognising individual anxieties that may exist. However, to date no patients had raised any significant issues. Whilst there was no defined date for time to settle, it would be expected that after three months, patients should be well integrated into new services and this would be monitored through key indicators e.g. incident reporting. Professor Thomson echoed this point and advised that experience had been taken from the more comprehensive move made to the newly built hospital in 2011, and that this experience would be less impactive given the focus on continuity of care for patients and a minimal number of staff moves. In respect of contingency planning, and issues arising would become business as usual clinical management.

Ms Fallon offered the view that this was helpful alongside the deep dive taken through the Clinical Governance Committee earlier in the month. She welcomed the development of an interim leadership model to support implementation, and noted that the committee would continue to take oversight on the detail of this. She also asked if any feedback had been received from carers, and Ms Merson advised that no substantial feedback had been received to date. Mr Moore commented that the upcoming carer events would provide another opportunity to engage with carers.

Mr Moore summed up the report as helpful and informative, with assurance being given on how the transition to the revised model was developing, with support for both patients and for staff throughout.

The Board were content with the progress made to date on implementation of the new clinical model, and that a further update would be presented to the next meeting of the Board.

<u>The Board:</u>

1. Noted the content of this update.

11 SUPPORTING HEALTHY CHOICES

The Board received a paper (Paper No. 23/06) from the Medical Director, to provide an overview of the Supporting Healthy Choices Group which supports TSH to manage the risk of obesity rates in patients. Professor Thomson presented the paper focused on the progress made against the associated action

Plan, and metrics. She explained that a Project Manager had been appointed in November 2022, through internal secondment but had since retuned to their substantive post. The post had been re evaluated, and would be re-advertised.

Professor Thomson also highlighted additional areas of focus for the group including the importance of meals being served in line with the agreed protocol to ensure these were not too compressed and met patients' needs; as well as the review of the Food Fluid Nutritional Care standards to fit with the new clinical model. She also emphasised the way in which increased time in rooms, due to service pressures, could impact here with patients having less access to activity, and more temptation for unhealthy eating. There was ongoing focus on access to fresh air and activity for patients with grounds access, as well any other possible activity within the possible limits.

The Board were content to receive this update.

The Board:

2. Noted the content of this update.

12 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning and Performance (Paper No. 23/07) which provided update reporting on progress made towards quality assurance and improvement activities since the date of the last Board meeting. Ms Merson summarised the key workstreams reported within the report, covering clinical audit work as well as variance analysis tools to identify areas for improvement. She highlighted the work of the Activity Oversight Group to monitor patient activity, and identify trends.

Ms Merson noted the continued development of quality improvement initiatives including training, as well as on evidence for quality through continued assessment shown through the evaluation matrix, with projected completion dates added to this.

Mr McConnell asked for further clarity in the way the use of PRNs (administration of medication that is not scheduled) was being reported. Ms Merson confirmed that this reporting was not in reference to the use of PRNS, but rather for reporting whether there was sufficient review of same; and added that the Medicines Committee was taking this forward in terms of action.

Mr Currie commented on how much valuable information was contained within this report; and asked if it were possible for the Board to have more focused summary about the positive aspects as well as any areas requiring improvement. This would help to focus scrutiny by the Board, as well as supporting mapping of these areas over time. Professor Thomson noted the importance of providing assurance to the Board on each of the areas included for reporting; and Ms Merson added that it would be possible to review reporting to provide a more focused summary. There was agreement by members that this should be taken forward for future reports. Ms Fallon added that detailed oversight on key areas would continue to be taken through the Clinical Governance Committee, with key themes being escalated to the Board. With respect to PRNs, Ms Fallon noted that it would be helpful to compare practice across hubs, as well whether there was any link to service delivery pressures. Ms Merson noted that this could be reviewed and form part of future reporting.

Action (s) – Ms Merson

There was further discussion more generally on assurance reporting routes through the governance committees to the Board. Mr Moore summed this up for the Board identifying a need for further consideration on the levels of oversight taken by the governance committees to enable more focused scrutiny by the Board as a whole. He would take this forward through initial discussion with Mr Jenkins and Ms Smith.

Actions – Mr Jenkins/ Ms Smith

The Board noted the content of the report, and the level of assurance it provided.

The Board:

1. Noted the content the report and updates contained therein.
2. Requested review to give more focussed summary reporting
3. Noted need to consider assurance routes to the Board and it committees more widely.

13 CLINICAL GOVERNANCE COMMITTEE

The Board received a copy of the approved minutes of the meeting of the Clinical Governance Committee that took place on 10 November 2022.

As Chair of the Committee, Ms Fallon provided a verbal update on the key items of business from the meeting which took place on 9 February 2023, which had included a detailed presentation on the implementation of the revised clinical model.

The Board:

1. Noted the approved minutes of the Clinical Governance Committee held on 10 November 2022.
2. Noted the verbal update from the Chair of the Clinical Governance Committee from the meeting held on 9 February 2023.

14 CLINICAL FORUM

The Board received a copy of the approved minutes of the meeting, which took place on 29 November 2022.

The Board:

1. Noted the approved minutes of the Clinical Forum meeting held on 2 9 November 2022.

STAFF GOVERNANCE

15 WORKFORCE REPORT

The Board received a report from the Director of Workforce (Paper No. 23/08) to provide an update on overall workforce performance to 31 January 2023.

Ms McGovern provided an overview of the report for the Board, including the key metrics outlined therein. In terms of work being progressed, she advised that the HR team had been re-structured to support line manager development within TSH, particularly for the Senior Charge Nurse cohort. Further, links made to the Business Disability Forum to help support reasonable adjustments as appropriate. Work was underway for the transition of occupational health services by way of the service level agreement with NHS Dumfries and Galloway. Finally, she provided an update on recruitment into nursing, including promoting TSH as an employer at recruitment fayres. There was focus on staff retention, with new ideas and focus in this area on listening to staff feedback.

Mr McConnell asked about performance in timescales through the recruitment process. Ms McGovern noted the responsibility of recruiting managers to manage this process to ensure that they can do so within the required timetable. HR supported managers in this including providing guides. Mr Currie commented on the importance of the PDPR process in enabling wider conversations with staff, and the usefulness of this feedback in helping the organisation to make future projections around staff retention and retirement demographics. He added that across NHS Scotland, providing training and leadership development had to be placed within the context of the possibility of staff moving on to a promoted post in another Board, rather than being a means to retain them.

Ms McGovern advised that exploration of vacancy turnover and age profile across staff cohorts was underway; and Ms McCaffrey added that this should also be linked to succession planning. This would be a focus of the Workforce Governance Group. Mr Moore noted that this was useful work and would be helpful in scrutinising the impacts of the Workforce Plan over time. He also noted the increase in sickness absence and the need to refocus on that, identifying any patterns or trends in this rise. For example, looking at staff groups as well as the length of service of staff affected, and add this to future reporting to the Staff Governance Committee.

Action – Ms McGovern

The Board noted the content of the report, including the rise in sickness absence and the actions being taken in response.

The Board:

1. Noted the content of the report

16 iMATTER REPORT

The Board received a report from the Director of Workforce (Paper No. 23/09) which summarised the key themes of the 2022 I Matter cycle for TSH within the context of national reporting. Ms McGovern underlined the high scoring areas for TSH that could be built upon further. Departmental teams had responsibility to create and take forward team action plans.

Ms McGovern advised that there were no proposed changes to the iMatter cycle for the current year, but that a question on whistleblowing would be added.

Members discussed the positive nature of the survey results, and that the Staff Governance Committee had reviewed this in detail leading to a helpful discussion about better understanding what staff were looking for when they highlighted the need for more visibility by Board Members and that this would be revisited at board development sessions.

The Board:

1. Noted the content of the report

17 WHISTLEBLOWING REPORTS

(a) WHISTLEBLOWING CHAMPION ANNUAL UPDATE

The Board received a report providing an annual update on the role of the Non-Executive Whistleblowing Champion at TSH (Paper No. 23/10).

Mr Moore noted that this role had been vacant and subject to a recruitment process and the position had been filled as of 16 January 2023. In these circumstances, he had prepared the update relating to 2022 for submission to the Cabinet Secretary for Health and Social Care.

The Board:

1. Noted the content of the report, and were in agreement with the content of the update provided for submission to Scottish Government.

(b) QUARTER 3 REPORT

The Board received a report from the Director of Workforce (Paper No. 23/11) which outlined activity in this area for Quarter 3 of this year. Ms McGovern confirmed that there had been no new cases during

this quarter although the Independent National Whistleblowing Office had advised TSH that they had received contact on one matter during the quarter and considered no action by TSH was required.

The Board noted this update.

The Board:

1. Noted the content of the report.

18 STAFF GOVERNANCE COMMITTEE

The Board received a copy of the approved minutes of the meeting that took place on 17 November 2022.

As Chair of the Committee, Ms Radage provided a further update on the main items of discussion at the most recent meeting that had taken place on 16 February 2023, including the change in provision of occupational health services, staff and volunteer wellbeing. The committee had undertaken a self-assessment exercise, which had been helpful especially around communication with key stakeholders.

The Board:

1. Noted the approved minutes of the Staff Governance Committee held on 17 November 2022,
2. Noted the verbal update from the Chair of the Staff Governance Committee from the meeting held on 16 February 2023

CORPORATE GOVERNANCE

19 CORPORATE OBJECTIVES 2023/24

The Board received a report (Paper No. 23/12) from the Head of Corporate Governance/Board Secretary seeking the Board's view on the annual re-fresh of Corporate Objectives.

Ms Smith described these as encapsulating the strategic priorities of the organisation for the next financial year, to support its key aims and mission. She underlined the way in which the Corporate Objectives should align with planning frameworks including the three-year workforce plan, and the annual delivery plan and medium term plan. The paper set out the assurance framework underpinning delivery of each objective, and the way in which these objectives inform performance monitoring across the directorate structure. Ms Smith referenced the next paper on today's agenda, which linked closely through setting out performance management arrangements.

Mr McConnell asked if there had been any sense of overarching change in the objectives for the coming year, and also asked about the read across of the Board's objectives through its governance committees. Ms Smith noted that performance against the Corporate Objectives were an integral part of the quarterly directorate performance meetings led by the Chief Executive; providing a mechanism for assurance reporting for the Board and committees. Ms Merson added that the objectives were signposted clearly as part of the performance workbook used to support the overall framework. Ms Smith also commented that a driver for change was found within the national planning objectives for service delivery and strengthening workforce in support of these.

Mr Moore suggested a minor amendment, with an addition to make clear the commitment to equality, diversity and inclusion. On this basis, the Board were content to approve the Corporate Objectives for 2023/24.

The Board:

1. Approved the Corporate Objectives for 2023/24, subject to one amendment as indicated, and these would be added to the website.

20 PERFORMANCE REPORTING

(a) TSH PERFORMANCE MANAGEMENT FRAMEWORK

The Board received a paper from the Head of Planning and Performance (Paper No. 23/13) which provided an outline of the TSH Performance Management Framework, developed within the context of the Active Governance approach led nationally.

MS Merson summarised the paper including how to define the principles of good performance management and the way in which these principles had been applied within TSH. She noted the way in which data was presented and analysed underpinned the quality of assurance reporting produced. She described the links from TSH to Scottish Government through quarterly performance meetings, and the development of a draft sponsorship agreement. Within TSH, quarterly performance meetings now took place for each directorate so that performance could be interrogated in detail, and this helped infirm planning for the future. The intention was to use the performance workbook as part of these meetings as a live document, to help colleagues to understand the framework and engage with it.

Mr Jenkins noted his support for the work in this area, which had gained pace within TSH and helped recovery from the covid-19 pandemic. This represented a performance management and governance approach to give assurance to the Board in the approaches being taken.

Mr Moore welcomed this paper, commenting on how important and useful it was for the Board. Mr Currie echoed this, commenting on the excellence of this work and the helpfulness of it. He noted that it supported scrutiny in defining what good performance looked like, as well as areas which required improvement. There was agreement around the table on these points, and the Board sought clarity that Ms Merson had the resources required to support this. Ms Merson advised that a project officer post was under development and that this would be key to continued success here, and this was welcomed and supported by the Board.

The Board:

1. Noted the content of the paper, supporting continued development of the performance management workstream.
2. Noted and supported the development of a project officer role within the department.

(b) PERFORMANCE REPORT QUARTER 3

The Board received a paper from the Head of Planning and Performance (Paper No. 23/14) which summarised organisational performance against Key Performance Indicators (KPIS) for Quarter 3.

Ms Merson led the Board through the paper indicating the areas that were off target in particular, the detail of which was contained within the report. She also advised that internal auditors RSMUK would be carrying out an audit in this area shortly and that reporting should be available for the next meeting of the Audit Committee in April.

The Board noted this update and that some key areas of performance had been discussed through other agenda items at the Board e.g. sickness absence within workforce reporting.

Mr Moore summarised for the Board, noting the helpfulness of this report in indicating performance across targets.

The Board:

1. Noted the content of the paper,

21 FINANCE REPORT TO 31 JANUARY 2023

The Board received a paper (Paper No. 23/15) from the Finance and eHealth Director, which presented the financial position to 31 January 2023, reporting on both revenue and capital resource spending and the projected yearend financial outturn.

Mr McNaught summarised the detail of the report, noting that this continued to be set on achieving a yearend breakeven position, with £0.811m efficiency savings. The Board was reporting an overspend of £0.044m to the end of January 2023, and this was mainly due to the cost of energy supply.
For the coming year, he noted that utilities costs remained a risk, and that baseline budgets set for 2023/24 would be subject to change depending on the Agenda for Change pay agreement being reached for 2023/24. He emphasised the impact of savings pressures for the next financial year, especially around the ability to create new posts and placing this in the context of that longer-term financial planning permitted variance of 1%. Alongside other NHS Boards, TSH was engaged with Scottish Government in respect of the allocation for the next financial year.

He also confirmed that it was expected that the capital allocation would be utilised within the current financial year, and that capital demands for 2023/24 were being confirmed.

Mr McConnell picked up on the potential savings pressures for the coming year, and that the non-recurring aspect of these should be recognised. He also asked whether the overspend related to utility costs was a timing issue, and Mr McNaught confirmed this point. Ms Radage asked for confirmation that the revised clinical model would be cost neutral in impact, and this was also confirmed. Mr Jenkins added further detail as to how the staffing model was developed and referenced the recent session the Board held by way of update on safe staffing legislation, which could entail a different projection of the staffing element in the future.

Mr Currie noted the degree of uncertainly for all NHS Boards and the public sector as a whole, with factors subject to change – most notably the cost of energy and inflationary pressures more widely. This meant that there would need to be detailed focus on ensuring that available funding was used most efficiently in areas where there could be confidence of consequential benefit. Mr McNaught noted that the differential in costs and pressures experienced across NHS Boards as well as the outlook for NHS Scotland as a whole would be led through Scottish Government with decision-making on Board allocations awaited. For TSH, there were higher staffing costs as a proportion of recurring funding meaning that it was more challenging to achieve savings. Given the essential nature of the service being delivered, there were fewer options available for making funding allocation choices.

Mr Moore summarised for the Board, noting the discussion across NHS Scotland on the benefit of service re-design as an essential part of managing service pressures and the capacity to meet demand. He commented on the need for TSH to be able to anticipate this question in the context of the specialist service offered, and that this would be an area of close focus for the Board in the coming year.

The Board:

1. Noted the content of the report.

22 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 23/16) detailing the update of the Perimeter Security and Enhanced Internal Security Systems re-fresh project and planning for the remainder of this year. Mr Walker presented this paper, acknowledging the concerns raised by the Board on progressing to finalisation of the project and that these concerns had been shared with the main contractor. He advised the Programme revision had been rejected and the revision 45 was

now being reviewed with the planned completion date being July 2023.

The Board noted this paper, and that a further update would be presented in a private session of the Board, given the security and commercial sensitivities.

The Board:

1. Noted this update in relation to the perimeter Security and Enhanced Internal Security Systems Project and recognised that this was a feature within the Private Session of the Board Meeting.

23 BOARD AND COMMITTEE MEMBERSHIP

The Board received a report (Paper No. 23/17) from the Head of Corporate Governance/Board Secretary to give an update on membership of the Board and each of its committees. Ms Smith presented an overview of this, recognising re-appointments to the Board as well as the appointment of a Non-Executive Director Whistleblowing Champion.

The Board:

1. Noted the content of the report.

24 AUDIT COMMITTEE

The Board received the approved minutes of the meeting of the Audit Committee held on 29 September 2022. As Chair of the Committee, Mr McConnell, provided a further update from the most recent meeting held on 26 January 2023, which had included an internal audit report on key financial controls and had also included an introduction to the new external auditors KPMG. The meeting had also received reporting on corporate risks, cybercrime as well as counter fraud and the recent reviews undertaken by the U.K Information Commissioners Office, and in respect to Network Information Service (NIS) arrangements within TSH.

The Board:

1. Noted the content of the approved minutes of the meeting held on 29 September 2022.
2. Noted the content of the verbal update provided in relation to the meeting held on 26 January 2023.

25 COMMUNCIATIONS UPDATE

The Board received a report (Paper No. 23/20) from the Head of Communication, which detailed continuing development of the communications service. Ms McCarron provided a summary of the key points including developing resourcing to the team as well as the introduction of the new website.

She advised that the post specific to digital communications was currently being advertised, with the hope that this would be successful. The website had gone live and a further update in this respect would be brought to the next development session of the Board in March. She also provided an update on the next key areas of focus including re-branding of the Board's logo, as well as the development of the intranet site. Responsibility for the intranet site would move to the communication's portfolio, and a development of this would follow aligned to SharePoint Online led as a national project.

The Board thanked Ms McCarron for this update, and for the contribution made to recruitment efforts through social media. There was agreement that the new website was transformation and an important contribution ot the way in which the Board presented itself publicly.

The Board:

1. Noted the content of the report provided.

26 ANY OTHER BUSINESS

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

27 DATE AND TIME OF NEXT MEETING

The next public meeting would take place on 27 April 2023, by way of MS Teams.

29 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 1.10pm.

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	April 2022	QA and QI	Update on Carer's clinic workstream	Monica Merson	To be Updated: April 23	Update June 2022: Progress with clinic in 2 Hubs during Feb – May 2022. Given positive feedback, further clinics will be held on 3-monthly basis. Feedback Reporting to be prepared end of November, and then update back to the Board planned for December meeting. **Update December:** This is part of Realistic Medicine Update – Completion of four clinics at a minimum required before detailed assessment could be undertaken, timing of final clinical was at end of November and work is underway and not yet complete. This should return to the Board as part of QA/QI report. **Update: February 2023:** Delayed update due to vacancy arising in project manager role, this is being reviewed by Head of Planning & Performance. **Update April 2023**: redeployed nursing resource temporarily in place to support Realistic Medicine, and update to next Board meeting. PCIT aware of this workstream, but no direct involvement.
2	October 2022	Operational Response Plan	Update on trigger points of escalation and link to the Board	K McCaffrey	To be Updated: June 23	**Update December 22:** Paper presented to Board advising of Task and Finish Group being set up to complete this work.

			resilience of loss of staff plan,			**Update February 23:** Group is underway, and continuing to meet – agreement that full revision of papers to be progressed in short time scale – update to Board in June 23 **Update April 23:** Workstream on track and update will come to next Board meeting.
3	Feb 23	CRR	Review of CE10, breakdown in corporate governance	M Smith	To be updated April 23	CE10 reviewed and update provided and agreed by Audit Committee to be included in board reporting on today's agenda **CLOSE**
4	Feb 23	QA and QI report	Review of report structure to give summary highlighting /key issues	M Merson	To be updated April 23	**Update:** Report reviewed and format changed to take this into account and give highlight reporting. **On agenda**
5	Feb 23	QA and QI	Review of assurance reporting thread through board versus committees	G Jenkins/ M Smith	To be updated April 23	**Update:** Commenced with Review of April agenda with Board Chair, and agreed of remit of items to committees as initial approach and this will be ongoing. Committee chairs also reviewing routing of business and will update Board Sec. Board development session in May will review Corporate Governance approach as a whole.
6	Feb 23	Workforce Report	More detailed exploration of trends and patterns of sickness absence – add profile of length of service as well as service area.	L McGovern	To be updated April 23	Reporting reviewed and presented under new format and ioncluding areas highlighted. **On agenda**

Last updated – 19.04.23 – M Smith

Author:
Margaret Smith
Head of Corporate Governance 01555 842012

Paper No 23/22

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 April 2023
Agenda Reference:	Item No: 7
Sponsoring Director:	Director of Security, Estates and Resilience
Author(s):	Risk Management Facilitator
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

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

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix 1.

3.2 Out of Date Risks

ND73 and HRD110 are both due for review

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

An update to the cyber security arrangements currently included in the Corporate Risk Register and Local Risk Register has been requested by CMT. This is currently under review and changes will be shared upon completion and presented to CMT.

CMT requested the addition of new corporate risk relating to the NIS (Network & Information System) Regulations. The risk assessment is currently in development with Director of Finance and Head of eHealth, the risk will be presented to CMT for approval and included in future Board updates.

3.4 Corporate Risk Register Updates

CE10 – Severe breakdown in appropriate corporate governance

The risk was reviewed in light of the strengthened positon of corporate governance arrangements and the way in which the Board navigated the impacts of the pandemic within existing standing orders. The risk assessment had been refreshed on this basis, but given the potential impacts of a severe breakdown, even rating the likelihood of this happening as rare means that the assessment remains graded as medium. Updated Risk Assessment available in Appendix 2.

CE15 - Impact of UK and TSH Covid-19 Inquiries on TSH

CMT reviewed the risk following a successful internal recruitment process to the role of Business Manager within Corporate Services as a 12 month secondment, and took the view that having this additional dedicated role in place provided substantial mitigation of the risk and allowed the grading to be revised to medium.

SD54 Implementing Sustainable Development in Response to the Global Climate Emergency

Climate Change and Sustainability Group reviewed risk and agreed to reduce risk to Medium based on the current compliance levels with DL (2021) 38. TSH is in a better than expected position with positive feedback from the Net Zero Route Map that is being produced for the site. Climate Change and Sustainability Group will continue to monitor progress and implement changes.

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has **4** 'High' graded risks. 2 risks, CE15 and SD54 have been downgraded from High to Medium as detailed in section 3.4 Latest updates are below:

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

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

Monthly Update: As part of the implementation of PMVA level 3 we have had training and development sessions for all staff involved from those providing the intervention to RMO's and Duty on call managers who are involved in the decision making process. There has also been additional refresher training added as it is anticipated that this level of intervention is not likely to be required regularly and will maintain staff competence and confidence.

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

Monthly Update: Statistics updated, less missing data resulting in increased overweight and obese levels. 82.1% overweight, 6.6% missing data.

- Counterweight monitoring system of pts will be on the new WMT platform on TURAS
- REHIS Food and Health training was successfully delivered in March to 9 staff with all passing the accredited course.
- SHC project manager to be re recruited
- Physical Health guidance info information included within clinical model guidance - further work with this required for specific groups
- 'Slim and Trim ' – need support to action a general wt management group, to support our pts after the HLG
- Use of GLP antagonist/Liraglutide – discussions with health centre, dietetics, pharmacy and Dr Alcock regarding TSH adopting
- SHC action plan review and update Spring 2023.

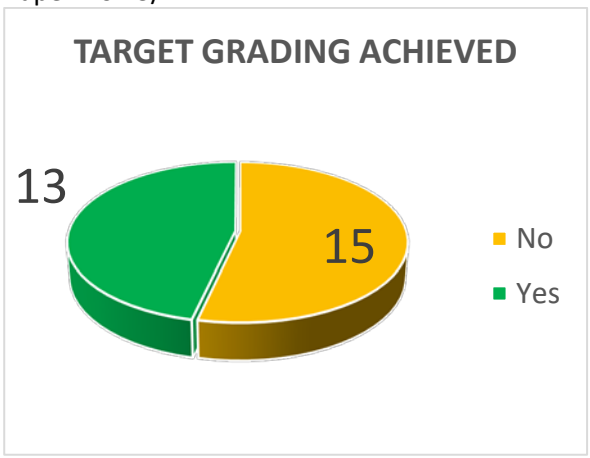
Nursing Director: ND70: Failure to utilise our resources to optimise excellent patient care and experience.

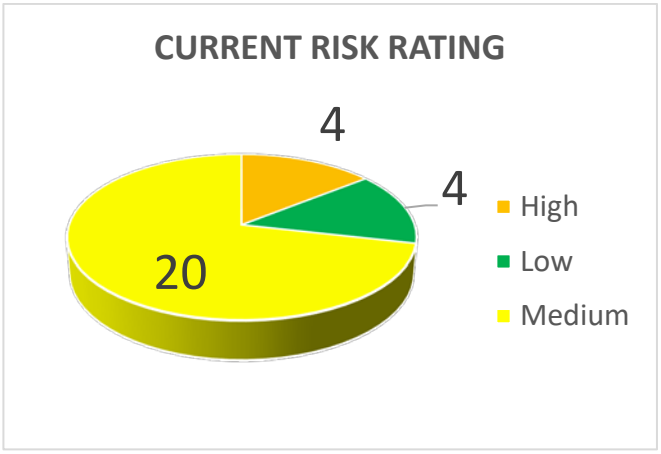
Monthly Update: Revised and improved the senior oversight of the resource meetings, completed a RSM audit and following output from this also improved recording of these forums. We have almost completed our Operational Response Plan which will replace the Loss of Staff Plan. Also, currently rolling out e-rostering and part of the safe staffing early implementer cohort again work from these will further support and enhance current practice.

Director of HR and Wellbeing: HRD111 – Deliberation Leaks of Information

Monthly Update: Short Life Working Group met to review the existing control measures and consider if any further action was required to mitigate risk. There are a number of control measures detailed within the risk assessment however the group felt that they could be strengthened. For example "staff are regularly made aware of their obligations regarding confidentiality" was tabled and the group agreed that this was only discussed at induction with no further communication thereafter . The group recommended Managers utilise their PDR meetings with staff at 3/6/12 months to remind them of their obligations and highlighting other policies that are in place if staff have concerns. Updated Risk Assessment is available in Appendix 4, changes are highlighted in yellow.

3.6 Risk Distribution





Currently 13 Corporate Risks have achieved their target grading, with 15 currently not at target level. 2 risks have been reduced since the last report, 2 from High to Medium, 1 of which is now at target level.

As per the TSH Risk Management Strategy, Low and Medium risks are tolerated within the organisation's risk appetite. While some of the Corporate Risks have not met their target level, they still remain within the agreed risk parameters. Ongoing work is underway to reduce risks to target level by the Risk Management Facilitator, risks are reviewed continuously and updated where required.

The Board is undertaking self-assessment of its risk appetite, and how this impacts management of risk. Further work is progressing to enhance oversight of Corporate Risks by each of the Board's governance committees.

A report detailing High and Very High Risks is now on the CMT Agenda each month. This will detail the current High and Very High Risks within TSH and owners will be asked to provide an update on progress i to reduce the level of risk. An example of the latest report is available in Appendix 3.

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely			ND70,	MD30,	
Possible			CE12, SD57, FD91, ND73, CE14	ND71, HRD111	
Unlikely			MD33, FD90, HRD110, FD96, FD98	MD34, SD51, SD50, SD54	
Rare			FD97, CE13, SD52, HRD112	MD32, SD56,	CE10, CE11, SD53, CE15

Review Periods:

Low risk	6 monthly
Medium risk	Quarterly
High risk	Monthly

Very High	Monthly (or more frequent if required)

4 RECOMMENDATION

The Board are asked to review the current Corporate Risk Register, as an accurate statement of risk; and to feedback any comments and/or additional information members would like to see in future reports.

Paper No 23/22
MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The report provides an update of the Corporate Risk Register.
Workforce Implications	There are no workforce implications related to the publication of this report.
Financial Implications	There are no financial implications related to the publication of this report.
Route To Board Which groups were involved in contributing to the paper and recommendations	Governance Committees
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

Paper No 23/22

High Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/05/23	Clinical Governance Committee	Monthly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/05/23	Clinical Governance Committee	Monthly	-
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	01/05/23	Clinical Governance Committee	Monthly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Possible	Moderate x Unlikely	HR Director	HR Director	16/05/23	Staff Governance Committee	Monthly	-

Medium Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	18/07/23	TSH Board	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	18/07/23	Clinical Governance Committee	Quarterly	-
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Risk Management Team Leader	18/07/23	Audit and Risk Committee	Quarterly	-
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	Major x Almost Certain	Moderate x Possible	Minor x Possible	Chief Executive	Chief Executive	18/07/23	TSH Board	Quarterly	-

		a safe and secure environment for patients and staff.									
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	01/07/23	TSH Board	Monthly	↓
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	20/04/23	Clinical Governance Committee	Quarterly	-
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	20/04/23	Clinical Governance Committee	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	20/04/23	Clinical Governance Committee	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	18/07/23	Audit and Risk Committee	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	18/07/23	Audit and Risk Committee	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	18/07/23	Audit and Risk Committee	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	18/07/23	Audit and Risk Committee	Quarterly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Unlikely	Moderate x Rare	Security Director	Head of Estates and Facilities	09/06/23	Audit and Risk Committee	Monthly	↓
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	18/07/23	Audit and Risk Committee	Quarterly	-

Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	18/03/23	Clinical Governance Committee	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	06/07/23	Audit and Risk Committee	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Possible	Moderate x Possible	Moderate x Possible	Finance & Performance Director	Head of eHealth	06/07/23	Audit and Risk Committee	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	06/07/23	Audit and Risk Committee	Quarterly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth/ Info Gov Officer	06/07/23	Audit and Risk Committee	Quarterly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	HR Director	HR Director	17/04/23	Staff Governance Committee	Quarterly	-

Low Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	01/06/23	TSH Board	6 monthly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	01/05/23	Audit and Risk Committee	6 monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	06/10/23	Audit and Risk Committee	6 Monthly	-

Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Rare	Moderate x Rare	HR Director	Training & Professional Development Manager	01/05/23	Clinical Governance Committee	6 Monthly	-

Appendix 2

Severe Breakdown in Corporate Governance Ref: CE10

Corporate Objective	Better Workforce	Risk Owner	Chief Executive	Action Officer	Board Secretary

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
The risk that the Board experiences a severe breakdown in corporate governance.	

Category		Tick the box to indicate the type of risk
Staffing	☐	
Financial & Organisational	☒	
Clinical	☒	
Physical	☐	
Project	☒	
Other (Specify)	☐	

Hazards		Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
• Failure to maintain and deliver the NHS Board and Committee scrutiny, and leadership arrangements. • Failure to meet Board and Committee performance requirements. • Failure to deliver on the organisation's core purpose. • Failure to deliver the NHS quality ambitions. • Failure to meet staff governance standards. • Failure to meet the organisation's statutory and mandatory requirements. • Failure to deliver the above within a balanced budget.		
Individuals or group exposed	Patients, Staff, Scottish Government	Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk being mitigated. (e.g. cost savings)

Existing Control Measures	List any existing measures in place to mitigate this risk.
1. Board Chair has lead Non- Executive role in ensuring that the Board and its committees appropriately discharge their governance and leadership responsibilities. The Chair is accountable to the Cabinet Secretary for Health & Sport and the Board is held to account through various mechanisms including the Annual Review Process / Annual Operational Plan / and Statement of Accounts. **2.** Non-Executives provide proactive feedback on any areas of concern in relation to governance and chair the various committees. **3.** The Chief Executive ensures that governance arrangements are effectively supported by the Executive Team through appropriate representation at committees; provision of good quality reporting and data; clarity of leadership direction. **4.** The Board Secretary leads all aspects of the Board Governance arrangements including advising on regulatory framework and any required meeting preparation. **5.** TSH reviews its corporate governance framework to ensure effective oversight, led by the Board Secretary. This is ongoing through board development sessions as well as formal Board meetings. This is conducted within the requirement of existing legislation, regulatory framework, and in reference to the existing Standing Orders of the Board. **6.** Further ongoing work was established in 2019/20 to look at refreshing the overall Corporate Governance Blueprint in line with all NHS Scotland Boards. This is ongoing with publication of version 2 of the blueprint through DL(2022)39 in December 2022 **7.** Organisational risks are regularly reviewed and addressed through the risk management system. **8.** The organisation ensures that feedback from external reviews is considered and any learning points promptly addressed. **9.** Governance arrangements are subject to regular self and external assessment. E.g. Internal / External Audit; Peer Review; Healthcare Improvement Scotland / Audit Scotland etc.	

Likelihood	Impact/Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the risk occurring and the impact it would have and determine the overall level of the risk.	**Impact/Consequence** (use descriptor relevant to proposal and select level of impact)	**Likelihood** (use descriptor relevant to proposal and select level of impact)	**Rating** R=I/C x L
Initial Risk Rating Risk grading without controls	Extreme	Possible	High
Target Movement Movement since last review	-	-	-
Target Risk Rating	Major	Rare	Medium
Current Risk Rating	Major	Rare	Medium

Further Control Measures Required	Include any additional controls identified to eliminate or reduce the risk further.
• Board Meetings should continue on agreed schedule, and that special meetings can be convened as required. • Assessment of ability to meet quorum for each meeting, in advance to mitigate risk and take action e.g. Board Chair can act as temporary member of clinical and staff governance committees. • Consider continued use of virtual and hybrid meetings to facilitate quorum. • Learning from pandemic experience through which the Board and Committees were able to continue to run, adjusting agendas and meeting arrangements to support this. • The business transacted at the Board and its committees will be formally reviewed by way of annual reporting, and governance statement.	

Assurances	What assurances are there that current controls are effective? (Internal and external)
Corporate Governance arrangement subject to internal audit process with rating of substantial assurance. Board and committee meetings, as well as framework of organisational management run effectively with no recorded inability to meet requirements of effective assurance and decision-making. Internal and external audit reporting through Audit Committee	

Key Performance Indicators	Detail any existing KPIs that would link to risk and show performance against risk
Ministerial Annual Review / Feedback Board and Committee self-assessments	

Date Added	July 2016
Completed by	Margaret Smith
Date Reviewed	28.03.23
Next Review	01.07.23

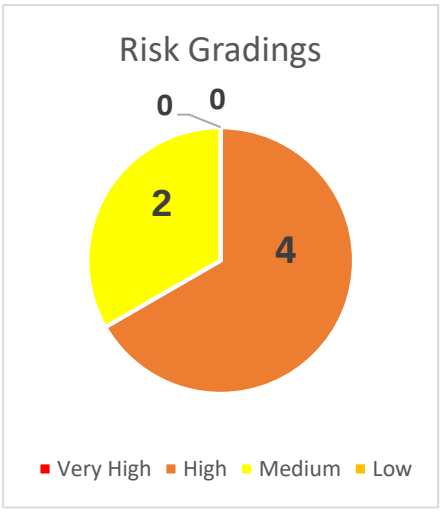
Risk Register	Corporate Risk Register
Directorate	Corporate
Group/Committee Monitoring Risk	Audit Committee/ Board

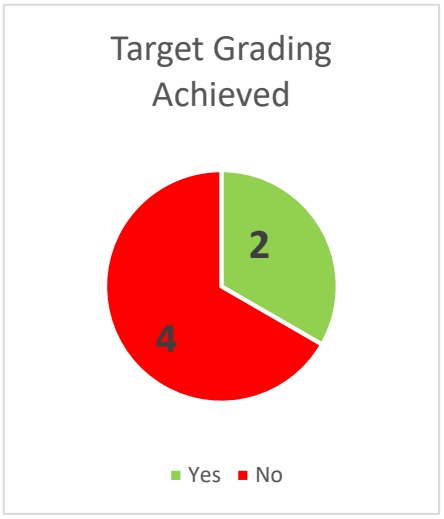
Appendix 3

FLASH REPORT

High & Very High Corporate Risk Register CMT Update

Committee/Group	Author	Date
Corporate Management Team	Stewart Dick, Risk Management Facilitator	5th April 2023





No Very High Risks	
High Risk Updates	
ND70 - Failure to utilise our resources to optimise excellent patient care and experience.	Revised and improved the senior oversight of the resource meetings, completed a RSM audit and following output from this also improved recording of these forums. We have almost completed our Operational Response Plan which will replace the Loss of Staff Plan. Also, currently rolling out e-rostering and part of the safe staffing early implementer cohort again work from these will further support and enhance current practice.
ND71 – Failure to assess and manage the risk of aggression and violence effectively.	As part of the implementation of PMVA level 3 we have had training and development sessions for all staff involved from those providing the intervention to RMO's and Duty on call managers who are involved in the decision making process. There has also been additional refresher training added as it is anticipated that this level of intervention is not likely to be required regularly and will maintain staff competence and confidence.
MD30 - Failure to prevent/mitigate obesity.	Statistics updated, less missing data resulting in increased overweight and obese levels. 82.1% overweight, 6.6% missing data. - Counterweight monitoring system of pts will be on the new WMT platform on TURAS -REHIS Food and Health training was successfully delivered in March to 9 staff with all passing the accredited course. -SHC project manager to be re recruited Physical Health guidance info information included within clinical model guidance - further work with this required for specific groups

	-'Slim and Trim ' – need support to action a general wt management group, to support our pts after the HLG -Use of GLP antagonist/Liraglutide – discussions with health centre, dietetics, pharmacy and Dr Alcock regarding TSH adopting -SHC action plan review and update Spring 2023.
HRD111 - Deliberation Leaks of Information	SLWG met to review the existing control measures and consider if any further action was required to mitigate risk. There are a number of control measures detailed within the risk assessment however the group felt that they could be strengthened. For example "staff are regularly made aware of their obligations regarding confidentiality" was tabled and the group agreed that this was only discussed at induction with no further communication thereafter . The group recommended Managers utilise their PDR meetings with staff at 3/6/12 months to remind them of their obligations and highlighting other policies that are in place if staff have concerns. Meeting will be written up and actions assigned to appropriate members of staff. The risk assessment will also be updated to include the actions from the meeting.
Reduced from High Grading	
SD54 - Implementing Sustainable Development in Response to the Global Climate Emergency	Climate Change and Sustainability Group reviewed risk and agreed to reduce risk to Medium based on the current compliance levels with DL (2021) 38. TSH is in a better than expected position with positive feedback from the Net Zero Route Map that is being produced for the site. Climate Change and Sustainability Group will continue to monitor progress and implement changes.
CE15 - Impact of UK and TSH Covid-19 Inquiries on TSH	CMT reviewed the risk following a successful internal recruitment process to the role of Business Manager within Corporate Services as a 12 month secondment, and took the view that having this additional dedicated role in place provided substantial mitigation of the risk and allowed the grading to be revised to medium.

Ref.	Category	Risk	Initial Grading	Current Grading	Target Grading	Director	Review Date	↓-↑
Corporate ND70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience.	Major x Possible	Moderate x Likely	Minor x Unlikely	Nursing, AHP and Operation	29/04/23	-
Corporate ND71	Health and Safety	Failure to assess and manage the risk of aggression and violence effectively	Extreme x Likley	Major x Possible	Major x Possible	Nursing, AHP and Operation	29/04/23	-
Corporate MD30	Medical	Failure to prevent/mitigate obesity.	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	01/05/23	-
Corporate HRD111	Reputation	Deliberation Leaks of Information	Major x Possible	Major x Possible	Moderate x Unlikely	HR Director	17/02/23	-
Corporate SD54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Moderate x Possible	Moderate x Rare	Security, Estates and Facilities	09/06/23	↓
Corporate CE15	Reputation	Impact of UK and TSH Covid-19 Inquiries on TSH	Extreme x Likely	Extreme x Rare	Extreme x Rare	CEO	01/06/23	↓

Appendix 4

Information Leaks Ref No HRD111

Location	The State Hospital	**Department**	Corporate Management Team	**Manager**	Director of Workforce

Risk	
Deliberate leak of information to the media (including patient and staff information)	Complete the relevant details of the operation/ activity giving risk to the risk

Type of Risk		
Staffing		Tick the box to indicate the type of risk
Financial & Organisational	√	
Clinical		
Physical		
Project		
Other (specify): Reputational	√	

Hazards		
• Breach of patient and/or staff confidentiality. • Non-compliance with General Data Protection Regulations. • Risk of fines and legal proceedings associated with data breaches/ breaches of confidentiality. • Reputational damage to the organisation as a result of adverse media reporting and/or data breaches. • Risk of staff losing professional registration by potentially breaching their Code of Conduct. • Risk of loss of trust in the organisation by staff, patients, carers, volunteers, regulators and other partners • Risk of negative impact on patients from hinder their recover to other patients discussing them.		Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
Individuals or groups exposed	Patients and staff	Highlight those who would be affected by risk

Benefits	
Reputational benefits for staff, patients, volunteers and key stakeholders on confidentiality. Governance assurances on abiding by standards	Detail any benefits associated with this risk being realised. (e.g. cost savings)

Existing Control Measures	
▪ All staff are regularly made aware of their obligations regarding confidentiality upon commencement of employment within TSH. This should be done every quarter via HR & Communications. ▪ A confidentiality statement is signed by all staff/volunteers when they commence employment/placements in the hospital as part of their induction. Follow up reminders should be given at their 3/6 and 12 months review and this will be included in the paperwork. ▪ All staff are required to complete an online learning module on Confidentiality. Completion of this module is included as part of core induction for all new staff/volunteers and is repeated every 2 years. Compliance is monitored and reports are provided to departmental managers on a monthly basis. ▪ All staff/volunteers are required to complete Information Governance Essentials online training on commencement of employment in TSH and thereafter on an annual basis. This provides an annual reminder to all staff of their contractual responsibility not to deliberately leak to the media, or other third parties, sensitive information regarding staff or patients. Compliance with the requirement to complete this module annually is monitored regularly and reports are provided to Departmental Managers by the Learning Centre on a monthly basis. ▪ Annual special bulletin is published on the risks associated with social media, highlighting the TSH policy and reminding staff of their responsibilities and consequences of breaches in confidentiality. ▪ Formal mechanisms are in place to support staff who may wish to highlight patient / staff safety issues via internal Whistleblowing Champion. Concerns can also be raised via the national confidential alert line. ▪ The NHS Scotland Conduct Policy provides a mechanism to ensure that appropriate formal action is taken against any staff member who is suspected to have deliberately leaked sensitive data regarding staff or patients to an external third party. ▪ Systems and processes are in place to ensure safe and secure storage, transmission and sharing of sensitive information relating to patients or staff. This includes: - Restricted access to TSH information systems that contain sensitive patient and staff data and in-built functionality within information systems to provide an audit trail of system access/activity. - Access to RiO is clustered by ward and staff members without the required authorisation to view specific patient records are required to utilise a 'break glass' function. When the 'break glass function is activated this is followed up to check that the reason for accessing the record was legitimate. Fairwarning provides weekly audit and alerts of then patterns of access are outwith the norms. - The number of staff members that have access to all patients' records within RiO is restricted and this level of access requires authorisation from the Caldicott Guardian. - Attendees at Clinical Team Meetings and CPA meetings are formally recorded. - Newspapers are monitored and staff / patient articles are removed before distribution to patients.	List any existing measures in place to mitigate this risk.

Likelihood	Impact/ Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Further control measures required	Include any additional controls identified to eliminate or reduce the risk further.
• Meta compliance system is utilised to ensure that all staff read the 'Protecting Patient Confidentiality NHS Scotland Code of Practice. Staff need to digitally agree to reading this. This will be undertaken every 2 years. • Audit to be agreed with HR as part of the wider changes to Meta Compliance.	

Date Added to CRR	06/08/2016
Completed by	Linda McGovern
Last reviewed:	17/04/23
Next review:	17/05/23

State which register risk referred to	Corporate
Overall owner of risk (Director)	Director of Workforce
Group/Committee monitoring risk	Staff Governance Committee

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the risk occurring and the impact it would have and determine the overall level of the risk.	**Impact/Consequence** **(use descriptor relevant to proposal and select level of impact)**	**Likelihood**	**Rating** **R= I/C x L**
Initial Risk Rating	***Major***	***Possible***	***High***
Target Movement	↓	↓	↓
Target Risk Rating	***Major***	***Unlikely***	***Medium***
Current Risk Rating	***Major***	***Possible***	***High***

Corporate Objective		Tick the box to indicate the corporate objective the risk aligns with
Better Care	√	
Better Health		
Better Value		
Better Workforce	√	

Assurances	What assurances are there that current controls are effective? (Internal and external)
• Signed confidentiality statements in staff files. • Policies available for raising concerns – grievance, dignity at work, whistleblowing. • Individual staff training records. • Information Governance training compliance data. • Break-glass monitoring reports / weekly Fairwarning Reports • Reports quarterly to Workforce Governance Group on compliance of the actions detailed previously. • All press requests are entered onto Datix to enable numbers / subjects can be reported and monitored via Communications Team	

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 April 2023
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Senior Nurse IPC
Title of Report:	Infection Prevention & Control Report
Purpose of Report:	For Noting

1. SITUATION

This report will highlight any key areas of concern/ progress in relation to Infection Prevention and Control (IPC) activity during the period 1st February to 1st April 2023.

2. BACKGROUND

The Infection Control reporting structure consists of several layers. The Infection Prevention and Control Group (IPCG) is the operational group. This reports into the Infection Control Committee which is the governance group, reporting through to the Clinical Governance Group. This group provides assurance reporting to the Clinical Governance Committee. This framework will enable the Clinical Governance Committee to take detailed oversight in this area. This report, which comes directly to the Board, has been reformulated to act as an exception report, highlighting any areas of particular activity or concern.

3. ASSESSMENT

INFECTION PREVENTION & CONTROL ACTIVITY

The Infection Prevention and Control Group have met on the 7 February & 7 March, with no areas of concern escalated to the Infection Control Committee, which was held on the 9 March. However, given the Covid 19 outbreak, there was a further reminder to staff regarding the importance of adhering to all IPC measures.

COVID-19 ACTIVITY

The number of patients that have tested positive for Covid19 during this review period is 32; with 154 from March 2020 (to 1 April 2023).

There has been an influx of respiratory illness over the Autumn/Winter months, demonstrated in the chart below:

Table 1: Location and Confirmed Covid19

Month	Ward affected	Confirmed patient cases
February	Lewis 3	2
March	Arran 1	2
	Arran 2	9
	Iona 2	9
	Iona 3	2*
	Lewis 1	2
	Lewis 2	2
	Lewis 3	1
	Mull 1	1*
	Mull 2	2

From this 32, 10 patients were not fully vaccinated (fully vaccinated being primary course plus all boosters).

MANAGEMENT OF THE COVID19 OUTBREAKS

This peak of Covid Activity saw the highest number of patients testing positive (32). Previous peak in June/July 2022 saw 30 patients test positive.

In July 2022, the State Hospital changed the Standard Operating Procedure for the Management of Suspected/Confirmed cases. This was approved by ARHAI. This new SOP meant that asymptomatic negative patients were not restricted if a patient tested positive on their ward. This mirrored changes at a national level.

Throughout this peak, the Senior Nurse for Infection Control continued to submit outbreak reports to ARHAI and had meetings with members of ARHAI who were involved in the writing/approval of the SOP to seek reassurance that the SOP remained the best approach. No changes to the SOP were advised.

There was no requirement for a formal Incident Management Team to meet given the liaison between the Senior Nurse for Infection Control and ARHAI.
The Forensic Mental Health Policy Unit are kept informed of Covid status within the hospital from the Board Secretary.

VACCINATIONS
No additional vaccinations have been administered during this review period with the Autumn 2022 vaccination programme ending on 31 March 2023. There are 2 patients that are eligible for their spring Covid19 booster.

4. RECOMMENDATION

The Board is invited to

1. Note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To provide the Board with specific updates infection control as well as any other areas specified to be of interest to the Board.
Workforce Implications	
Financial Implications	No financial implications identified.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Nursing and AHP Directorate Board requested information.
Risk Assessment (Outline any significant risks and associated mitigation)	Not identified for this report.
Assessment of Impact on Stakeholder Experience	Not identified.
Equality Impact Assessment	Not formally assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not identified as relevant.
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:	27 April 2023
Agenda Reference:	Item No: 9
Sponsoring Director:	Medical Director
Author(s):	PA to Medical Director
Title of Report:	Bed Capacity within The State Hospital and Forensic Network
Purpose of Report	For Noting

1 SITUATION

Capacity within the State Hospital and across the Forensic Network has been problematic and requires monitoring.

2 BACKGROUND

a) TSH

The following table outlines the high level position from the 1 February 2023 until 31 March 2023.

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	5	0	5
Discharges / Transfers	1	1	2
Average Bed Occupancy: Available beds/All beds			88.3% 75.7%

Please note that in total there were 109 patients as of 31 March 2023, within this number 14 patients are under the care of the Learning Disability service (the service ais currently 2 patients in excess of their 12 patient allocation).

15 patients have been identified for transfer from TSH and 9 have been fully accepted for transfer. We have one MMI patient at TSH under the Exceptional Circumstances clause.

b) TSH Contingency Plan

A contingency plan has been finalised through CMT. This remains as follows:

I Ongoing Actions

a) Formal transfer review meeting established on a monthly basis (AMD)
b) Monitoring of imminent transfers (next 2-3 weeks) at weekly Patient Pathway Meeting and likely bed state reported to directors weekly (AMD)
c) Regular meeting in place to discuss with NHS Greater Glasgow and Clyde fully accepted patients for transfer to Rowanbank Clinic (CEO).

II Additional Actions agreed by CMT in the event of further bed pressure:

a) Use Mull 3 for patients to sleep in but to be located in another ward during day. 2 staff required to open ward at night. Facility time would not be possible. Establish operational group to plan this (ND).
b) Any agreement to use last bed must be with AMD / MD consent or out of hours with duty director consent. Communicated to RMOs (MD).

c) Forensic Network Capacity

The Board received copies of the Forensic Network's short-, medium- and long-term plans to improve capacity across the forensic estate. These were requested by Scottish Government. A copy of the weekly bed report across the Forensic Network is attached dated 10/04/23 – see below. The Orchard Clinic has temporarily reduced its capacity by 7 beds for urgent repairs.

Copy of 10.04.23.xlsx

3 ASSESSMENT

The current bed situation within TSH remains eased but it is recognised that there is a natural variation in the number of referrals and admissions and further pressure is likely in the future unless the medium and long term plans outlined by the Network are progressed. The Orchard Clinic's temporary closure of 7 beds for urgent work will cause further pressure across the forensic estate.

4 RECOMMENDATION

The Board is asked to note the report.

MONITORING FORM

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

Paper No: 22/25

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 April 2023
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	Head of Planning and Performance Consultant Psychiatrist
Title of Report:	Clinical Model Implementation – Update
Purpose of Report:	For Noting

1 SITUATION

Planning for Implementation of the Clinical Model was in an advanced stage prior to the Coronavirus pandemic. Work was paused in March 2020 and restarted in June 2021 to consider the current context, previous work carried out and what the future conditions would require prior to any restart. Planning and engagement has progressed. This paper updates the Board on progress towards implementation following the last update in February 2023

2 BACKGROUND

The clinical care model describes the way The State Hospital provides high secure services to patients with a mental disorder many of whom have offended. The need to review the Clinical Care Model arose from issues raised through a staff engagement exercise which focused on readiness to change. At the Board meeting in June 2022, the Board approved Project Initiation Document which provided detailed plans for the implementation of the model. A project group has formed to take forward planning for the implementation of the new Clinical Model. The Board have received regular updates since implementation commenced, with the last update being at the February Board meeting.

3 ASSESSMENT

As the implementation phase of the project continues, project implementation activities and processes have included

- The Clinical Model Implementation Short Life Working Group continue to meet monthly
- The Project Plan is updated regularly and attached for information (Appendix 1).
- The Project Oversight Group have met monthly.
- Updating issues log and escalation of issues to the Project Oversight Board to support project management and effective decision-making.
- The Project Group meet weekly to progress project planning and management

Below is an update from progress achieved since the last report to the Board in February 2023

Clinical Guidance

- Clinical Guidance Groups have formed and have provided a third draft of the clinical guidance for each of the clinical sub specialities.
- These clinical guidance documents have been reviewed by the Project Oversight Board at their February meeting and feedback provided to the groups.
- The Service Specific Guidance Documents have now been embedded within the overall Clinical Guidance Document to provide an overarching guidance document. This has been drafted to provide coherence across the pathway and ensure that there is consistency of approach in key processes.
- A Task and Finish group has been established to complete the following actions :
    - Provide alignment and coherence and ensure that across the service specific guidance documents are consistent with the overall vision and recovery focus.
    - Review and agree the referral process between each service
    - Ensure that the contingency plan and approach is embedded in the document and reflected in the services
    - Review the KIPs on a service and macro level to ensure appropriate monitoring and reporting
    - Ensure that the approach to planning and delivery of activity adopts a recovery model and makes effective use of resource in the Skye Centre and across the site

Patient Mapping and allocation to sub specialities

- Patient mapping exercise was carried out in January and planning for patient moves carried out in February
- Initial patient moves from Iona 1 to Arran 3 were carried out mid March
- Patient moves have been paused since a Problem Action Group (PAG) for Infection Control met in the 13th March due to high levels of Covid 19 across the TSH site. A further group was convened on 12th April and 19th April to review options and provide guidance on the movement of patients when there are positive cases of Covid 19.
- Replanning for patient moves restarted in mid April with patient moves planned to take place from end April. These will be ongoing until all patient have successfully being allocated to the correct service

Contingency Planning

- A contingency planning group have met to develop plans for addressing an excess of Major Mental Illness (MMI) patients to bed within the MMI services, should that position be realised following implementation of the model.
- A preferred option was selected with excess MMI patients boarding in the ID service at night and day care proved by referring ward.
- A SOP was developed for this approach and raised a variety of logistical and care quality issues which have been escalated to the POB. Options for further progression of the approach to contingency planning will be further discussed, however it should be noted that with current patient numbers, TSH would utilise the contingency plan when the Clinical Model moves are complete.

Communications – Patients

- In February all patients have had a 1:1 discussion with their RMO, or deputy, regarding whether they are moving or not. This has been followed up with a letter detailing the service, hub and ward they are moving to. Patients have been informed the moves will take place in March.
- In February patient carers were also informed of the imminent patient moves.

- Due to the pause in moves as a result of Covid infections in March, patients were informed of the delay with posters being displayed in all wards.
- As a result of the pause in patient moves, re planning of patient moves took place in mid – April
- Following patient movement replanning, patients will be informed and updated on new dates, any change to RMO and key worker.
- Engagement with Advocacy and PCIT have taken place to support patients at this time.

Communications – Staff

- To support staff communications, monthly update reports in the form of flash reports, summarising the month's activities and detailing the next steps, were issued in February and March (Appendix 2 and 3). These flash reports have been extensively shared and paper copies have been in place within hospital reception to ensure whole workforce remains informed regarding progress of the Clinical Model.
- In addition, there is a specific intranet page which holds all Clinical Model information.
- A project team e-mail is available for staff to engage with the project.
- The TSH weekly staff bulletin has carried updates for staff and all user e-mails have been distributed to inform staff of progress.
- Communications and Engagement Plan has been reviewed and updated.
- A Clinical Model session was held as part of the 'Seminar Series' in February to raise awareness and update staff
- Key workers of patients who are moving have been informed of patient moves and indicative timescales to provide support to patients

Workforce

- The Workforce Group have met and developed plans for some minimal initial staff movement required prior to patient moves. The group has also supported professional groups to consider how they allocate staff across the sub specialties.

Service Leadership

- Discussions have taken place to describe and scope and responsibilities of the Hub and sub speciality leadership across the Hubs.
- Proposed approach to service leadership is in development and an interim approach to support service leadership which will be in place to support the initial stand up of the services is also in development.
- The PPG have remained active in planning for the Clinical Model and have had discussions with key staff members to ensure patients perspectives and integral to plans.

EQIA/DPIA

- EQIA has been drafted and escalated to the POB for sign off
- DPIA has been approved by the Data Controller..

4 RECOMMENDATION

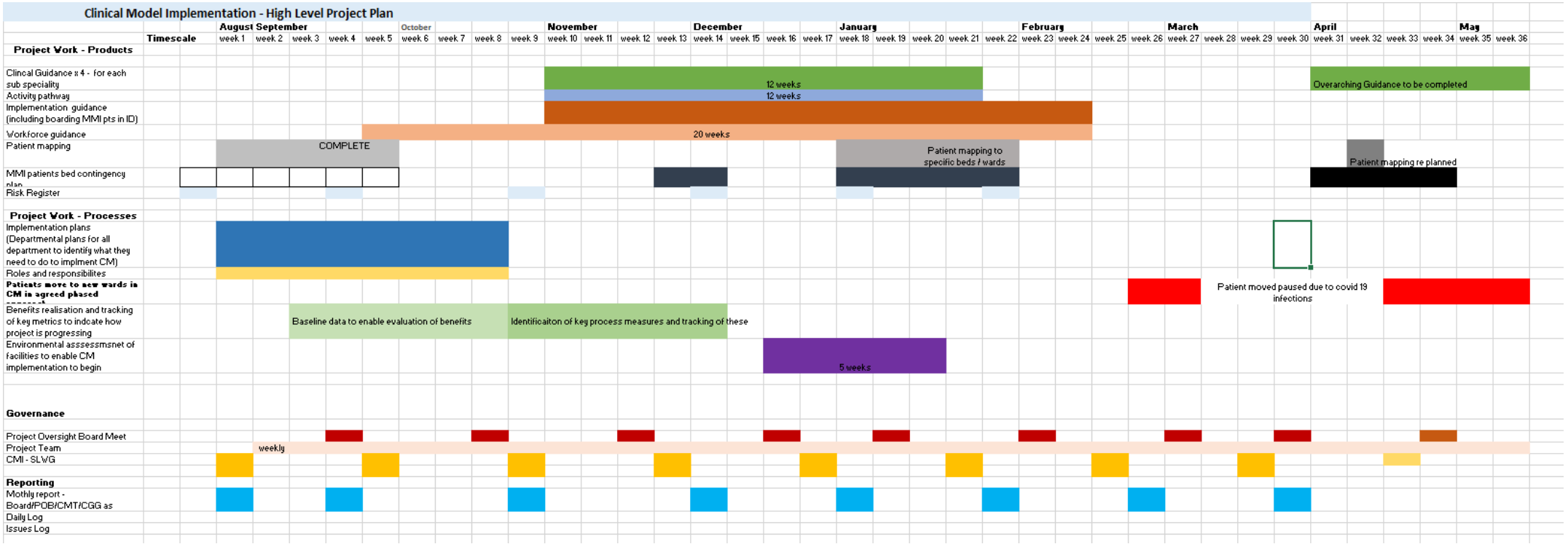
Board members are asked to:

- Note the contents of the attached documents.
- Discuss the implication of these for TSH.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports the implementation of the Clinical Model
Workforce Implications	Some of the actions may result in additional workforce resources being required
Financial Implications	As above
Route To The Board Which groups were involved in contributing to the paper and recommendations	Corporate Management Team and Clinical Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Risk that the current patient population will not fit into the clinical model
Assessment of Impact on Stakeholder Experience	Stakeholder experience may by impacted due to the new model being unable to be implemented at this time
Equality Impact Assessment	An EQIA has been completed for this project in 2020
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: Project Plan V5 April 2023



Appendix 2: February Flash Report

Clinical Model Flash Report – February 2023

Successful implementation is a shared responsibility.

Aim of Report:

The Clinical Model describes how clinical care is structured and delivered. As we move into the implementation stage for the new Clinical Model, we will provide a monthly report on work that has been delivered recently and describe the plan for the coming months. The aim is to have patient moves completed by the end of March 2023.

Clinical Model Activity in February 2023:

- Clinical Guidance reviewed by POB
- SOP developed for bed contingency – to be reviewed by CMT in March
- Second phase of staff moves carried out
- Planning for patient movement continues – options for the sequence of movements reviewed and agreed by POB
- Patient engagement carried out, 1:1 discussion completed to inform patients / carers if moving and if so, what ward / hub
- Interim leadership approach developed
- Seminar Series held and staff update in bulletin

Overview of the New Clinical Model:

The Clinical Model had been developed to provide an enhanced treatment environment with a focus on recovery. There are four sub specialties within the model – Admission and Assessment, Treatment and Recovery, Transition and Intellectual Disability.

Planned Work in March 2023:

- Continue development and engagement on interim service leadership approach
- Finalise Clinical Guidance
- Fully develop plan for patient movement
- Commence patient movement
- Continue with targeted patient communication to support patient movement
- Review department plans for service delivery

Planned Meetings – March 2023

Clinical Model Implementation SLWG:
28 March 2023
Clinical Model Project Oversight Board:
22 March 2023

Key Project Milestones:

To deliver the Clinical Model, the following Key Planning Elements require to be developed:

- Clinical Guidance.
- Workforce Guidance.
- Guidance for the physical movement of patients.
- Patient Mapping.
- Activity Pathway.

Communication and Engagement:

PPG have Clinical Model as a standing item and have started to consider what they need in preparation for the model.
Clinical Model Project Team will attend Partnership Forum monthly.
All Heads of Service are encouraged to include the new model as a standing agenda item in their team meetings.
TSH Clinical Model intranet page can be accessed here.

Next Steps:

Contact Details:

- If you have any queries or concerns, please contact the Clinical Model Project Team on: TSH.ClinicalModelProjectTeam@nhs.scot

Appendix 3: March 2023 Flash Report

Clinical Model Flash Report – March 2023

Successful implementation is a shared responsibility.

Aim of Report:

The Clinical Model describes how clinical care is structured and delivered. As we move into the implementation stage for the new Clinical Model, we will provide a monthly report on work that has been delivered recently and describe the plan for the coming months. The aim is to have patient moves completed by the end of May 2023.

Clinical Model Activity in March 2023:

- Clinical Guidance documents for the 4 services reviewed by POB and overarching guidance document in development
- Initial set of patient moves carried out with Iona 1 moved to Arran 3
- Patient moves paused due to increased number of Covid 19 infections across TSH
- Review of options to take forward activity in the Transitions Service

Overview of the New Clinical Model:

The Clinical Model had been developed to provide an enhanced treatment environment with a focus on recovery. There are four sub-specialties within the model – Admission and Assessment, Treatment and Recovery, Transition and Intellectual Disability.

Planned Work in April 2023:

- Planning for patient moves to recommence
- Patient moves expected to restart later in April
- Continue work on the Contingency Plan
- Continue to work towards completion of the overarching Clinical Guidance
- Establish Interim Service Leadership Teams
- Agree approach to activity across all services
- Update patients with revised plans for movement and clinical team information where available

Planned Meetings – April 2023

Clinical Model Implementation SLWG:
25 April 2023
Clinical Model Project Oversight Board:
26 April 2023

Key Project Milestones:

To deliver the Clinical Model, the following Key Planning Elements require to be developed:

- Clinical Guidance.
- Workforce Guidance.
- Guidance for the physical movement of patients.
- Patient Mapping.
- Activity Pathway.

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Next Steps:

Contact Details:

- If you have any queries or concerns, please contact the Clinical Model Project Team on: TSH.ClinicalModelProjectTeam@nhs.scot

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 April 2023
Agenda Reference:	Item No: 12
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Performance Head of Clinical Quality
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1. SITUATION

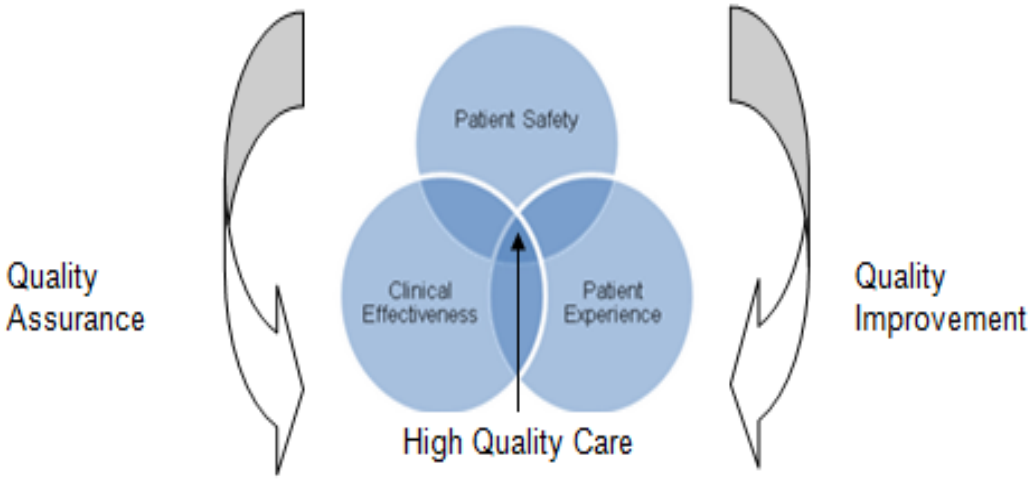
This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in February 2023. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational learning and development. It contributes to the strategic intention of The State Hospital (TSH) to embed quality assurance and improvement as part of how care and services are planned and delivered.

2. BACKGROUND

Quality assurance and improvement in TSH links to the Clinical Quality Strategy 2017 – 2020. TSH will work towards updating and revising the Clinical Quality Strategy in 2023. The current Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. It outlines the following seven goals to ensure the organisation remains focussed on delivering our quality vision:

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

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



3. ASSESSMENT

The paper outlines key areas of activity in relation to:

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

4. RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The quality improvement and assurance report supports the Quality Strategy and Corporate Objectives by outlining the actions taken across the hospital to support QA and QI.
Workforce Implications	Workforce implications in relation to further training that may be required for staff where policies are not being adhered to.
Financial Implications	Covid monies have been approved to continue with the Daily Indicator Report due to Clinical Quality Dept staff workload/weekend working.
Route to Board (Which groups were involved in contributing to the paper and recommendations)	This paper reports directly to the Board. It is shared with the QI Forum
Risk Assessment (Outline any significant risks and associated mitigation)	The main risk to the organisation is where audits show clinicians are not following evidence based practice.
Assessment of Impact on Stakeholder Experience	It is hoped that the positive outcomes with the 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 teamwork for any of the QI projects within the report.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

QUALITY ASSURANCE AND IMPROVEMENT IN TSH APRIL 2023

ASSURANCE OF QUALITY

Clinical Audit

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

Due to the imminent move of patients to align to the new services in the clinical model, a decision was made to pause most audit work as the team that was caring for the patient at the time of the audit, will not be the same team caring for them when the recommendations are published. As soon as the patient moves have taken place we will resume our plan of work with the backlog of audits being the priority.

The audit reports that have been approved since the last Board Meeting in February 2023 are:

- RMO record keeping
- RiO Validation

RMO Record Keeping
The data from February was very positive, with only 1 patient not being seen by an RMO during the month, but the patient had been seen on 30th January. No areas of concern.

Rio Validation
RiO validation is important to the hospital, as the entry within RiO is not a legal entry until validated. Very good compliance noted from all disciplines. No areas of concern.

Variance Analysis Tool (VAT) – Flash Reports

Flash reports were introduced in October 2022 to provide a very quick overview of the areas within the VATs that are either improving, or require some attention. The February 2023 report is below for information. As can be seen, staffing challenges in some departments are reflected within the data.

Data showing improvement from last report
Overall VAT Completion remained at 97% **Medical** – All Risk Assessment documentation was reviewed for the 2nd consecutive month. **Social Work** – Social Work interventions continue to be consistently good over time. **Psychology** – All Psychology interventions improved in Feb 23. VAT completion was 100%: Discussion of the report with the patient increased from 50% in Jan 23 to 60% in Feb 23; Provision of the annual report increased from 60% to 80% and Psychologist attendance increased from 73% to 91%. Attendance has shown sustained improvement from Sept 22. **Security** – Provision of of the security report increased from 90% in Jan 23 to 100% in Feb 23

Skye Activity Centre – Provision of the SAC report increased from 29% in Jan 23 to 100% in Feb 23. There was also a slight increase in discussion of report from 14% to 33%.

Data showing concern from last report

Medical – Completion of Medical Interventions decreased from 100% in Jan 23 to 92% in Feb 23. Due to this there were decreases in most interventions. PANSS assessment completion decreased to 20% in Feb 23 and is at its lowest level since June 22.

Nursing –- Overall completion of Nursing interventions decreased from 98% in Jan 23 to 88% in Feb 23 - completion on Mull was 100%. Discussion of the nursing report with the patient prior to the case review decreased from 87% to 64%.

KW/AW attendance decreased from 67% in Jan 23 to 34% in Feb 23.

Occupational Therapy – Results continue to be affected by staff vacancies. Although it should be noted that attendance at case reviews was maintained

Pharmacy –- Results have been affected by staff vacancies and workload since Nov 22. Provision of the Pharmacy report decreased from 53% in Jan 23 to 36% in Feb 23 and attendance decreased from 47% to 27%.

Security – Security attendance decreased from 73% to 36% - this was due to staff not being on duty or having other commitments.

Dietetics – All Dietetic interventions decreased in Feb 23: provision of report decreased from 90% in Jan 23 to 60% in Feb 23; discussions of report decreased from 80% to 20% and Dietetic attendance decreased from 60% to 40%.

Any challenges with the systems that are being addressed

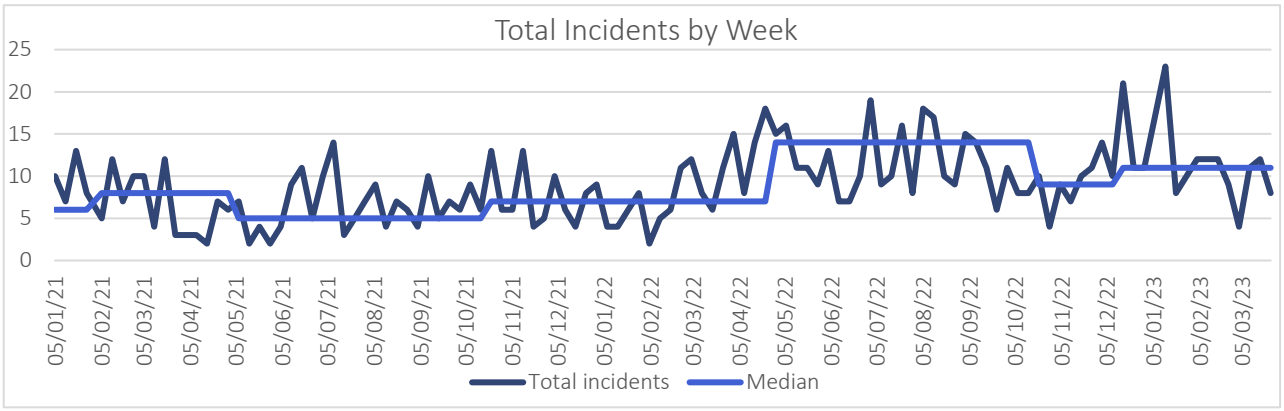
Met with SCN's and Request for Change Form being forwarded to EHealth to add 2 sub types to the RiO progress notes – CPA report discussion with patient to Case Review and Therapeutic Nursing 1 to 1. The first being to address the poor evidence of nursing staff discussing the CPA report with the patient prior to the review and the 2nd to eliminate having to record Nursing and KW/AW 1 to 1's on both RiO and Timetables.

Clinical Quality Flash Reports to Activity Oversight Group

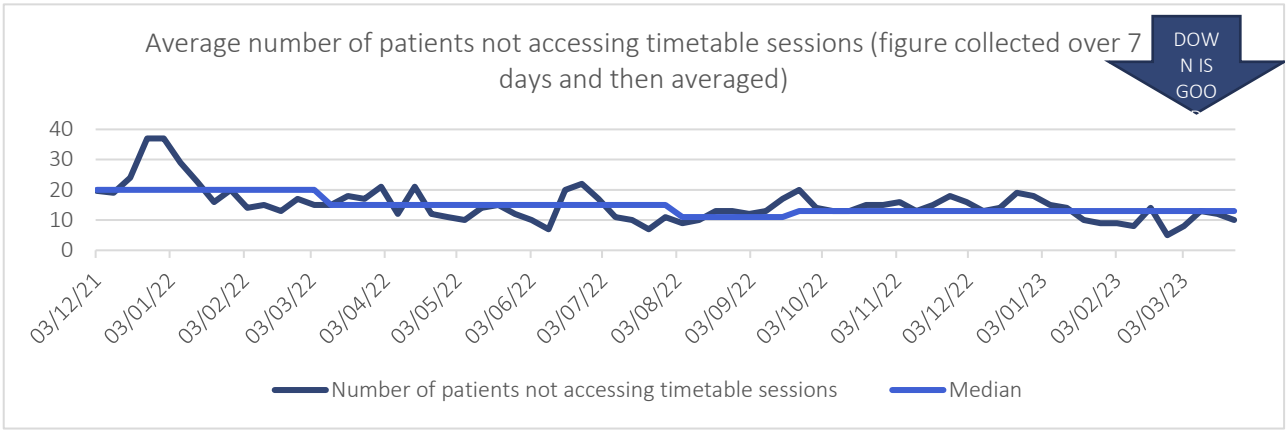
The Activity Oversight Group took over the role of monitoring the activity data earlier this year. Clinical Quality now produce a flash report for each meeting that highlights areas of improvement, concern and any system issues. The most recent report is below and will be discussed in full at the Activity Oversight group.

Data showing improvement from last report

Assaultive and behavioural incidents have decreased over the last few weeks after seeing a peak at 23 incidents in one week in January.

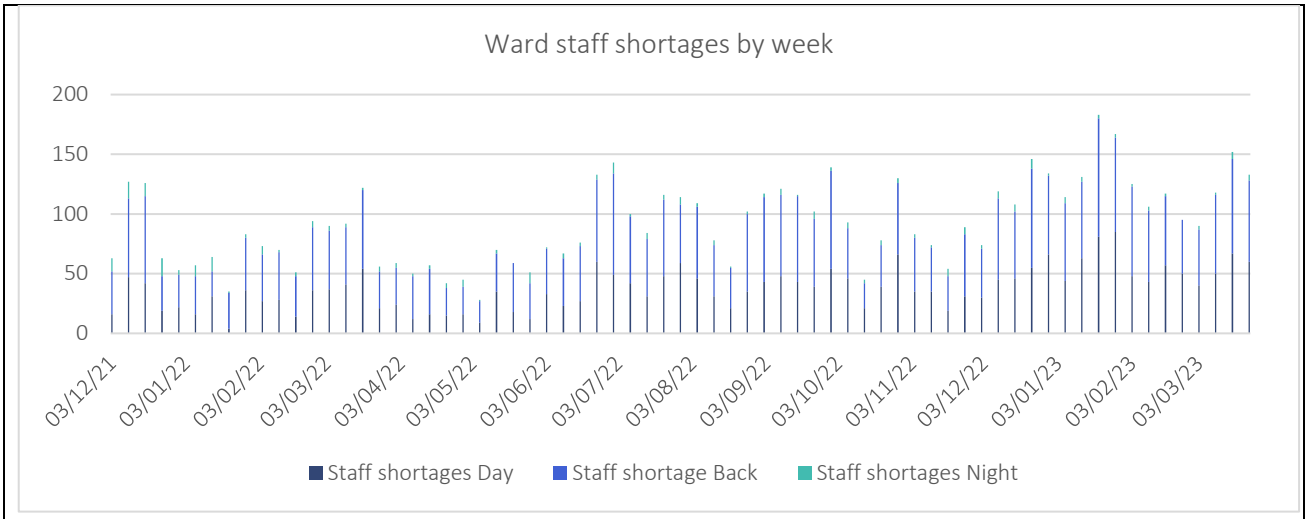


The number of patients not getting timetable activity has stayed below the median, even with the challenges the outbreak of Covid brought to the hospital:

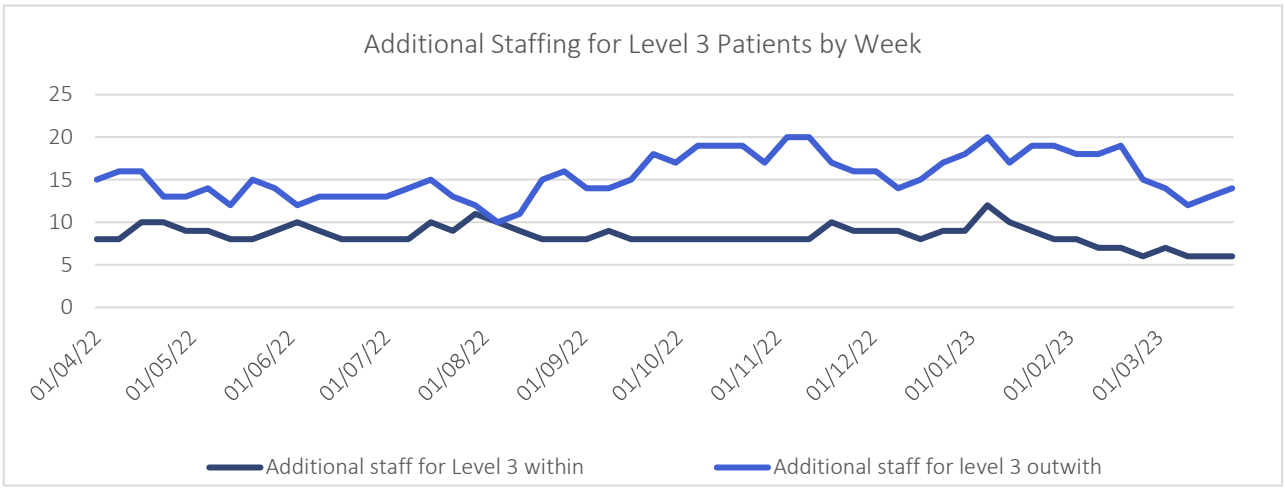


Data showing concern from last report

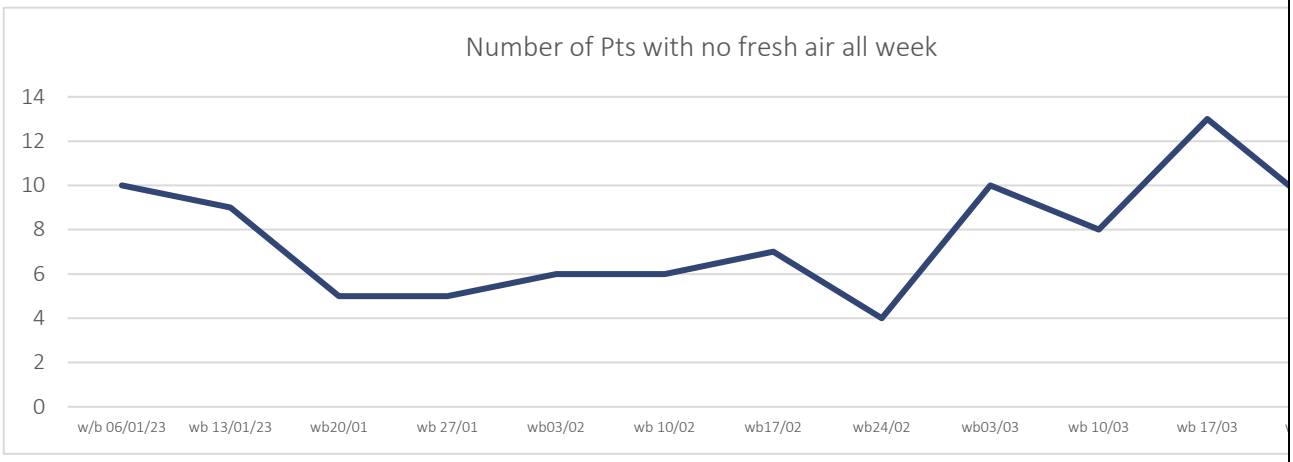
After a more settled period in February, ward staff shortages have seen increases over the last few weeks. This may be linked to the number of wards impacted by the Covid outbreak within the hospital:



New admissions requiring additional staff have also increased the number of additional staff required for patients on level 3 observations. This is still less than the number required at the end of 2022:

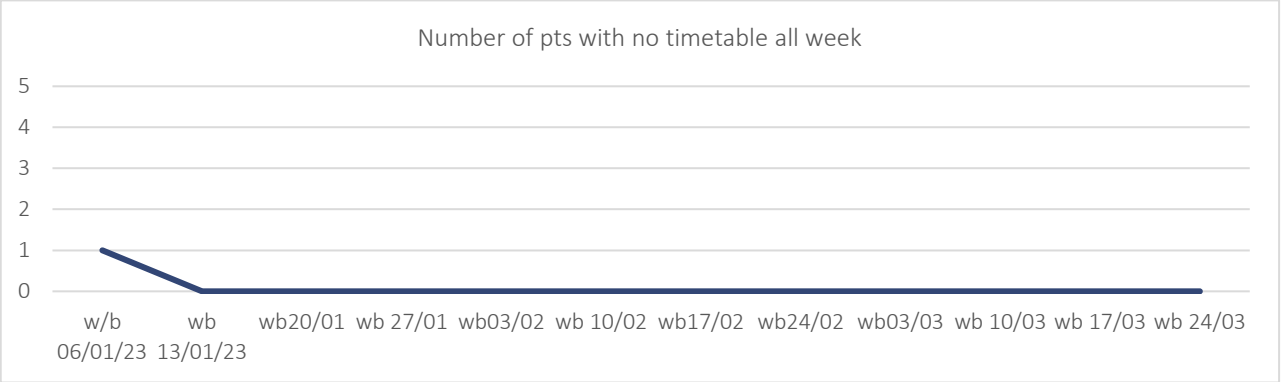


Although the number of patients not getting fresh air at any point in the week has started to improve following the covid outbreak, this is still higher than mid-late January:



Areas with sustained levels

All patients within the hospital have received some form of timetable activity each week:



What areas have been worked on in relation to systems in the last month

We have entered the Live Testing phase for the project to archive the physical activity forms and see all activity data coming from the timetable. This will reduce the amount of duplication for staff when a patient has any form of physical activity, but will still allow us to collect the KPI data required by the Board.

QUALITY IMPROVEMENT

QI Forum

The QI Forum's purpose is to champion, support and lead quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. The QI Forum met recently and has a focus to raise awareness and build capacity to support and embed QI. A QI projects database has been developed and updated to reflect the range of projects being taken forward across TSH.

QI Capacity Building

Planning is underway locally for two cohorts of QI essential training to be delivered for TSH staff in June and August. Three colleagues have commenced the ScIL training in January 2023 on cohort 43. This course will continue throughout 2023. Project planning has started for each participant. TSH have been successful with one application for the Scottish Coaching and Leading for Improvement Programme (SCLIP). This will commence later in the summer.

Staff awareness raising activities has been taken forward to raise the profile of QI. A staff bulletin has been issued, QI project posters have been updated at the reception area and an offer extended to staff to join the QI Forum if interested in further QI development work.

Early planning is underway to offer another round of TSH3030. The aim of this would be to support new teams in QI activity following the implementation of the Clinical Model.

To update the Board on current QI Projects in TSH, the following case study is presented to highlight QI in practice.

QI Project to introduce a template to the 0830 Huddle to give assurance all options have been considered before we go to a modified or closed ward model:

This project commenced on 22nd February with a template being introduced (appendix 1) to ensure that the group capture all the various elements that should be considered each morning to try and minimize patient disruption and maximize opportunity for patient activity.

Rapid plan, do, study, act (PDSA) cycles were used daily with any required enhancements to the template actioned for the next day. The group quickly realized the complex elements of patient care that required to be considered e.g. outings, visits, admissions, tribunals/court and issues in the Health Centre that require additional support to allow planned patient appointments to go ahead. The group are currently using version 10 of the planning template which includes greater detail to inform decision making than version 1 (appendix 2).

Work continues to enhance this template with the more recent addition being an automated pull of data from excel to reduce the duplication of data entry.

Through the process of prioritizing patient activity the group have also instigated a change in practice. Previously, Hub Activity staff were allocated into the ward numbers which allowed the patients up into the main day area (reducing the time they were in their rooms). Through review of the data, the group identified that physical activity and fresh air data was decreasing as the Hub Activity staff could not take patients (who do not have grounds access) out for walks if they were included in the ward numbers. A decision was made that on occasion the ward would go to a modified model (this is where patients can get up into the day room in a bubble of 6) and have the Hub Activity staff concentrating on escorting the patients for walks either as a 1-1 or in a group. This increased the physical activity and fresh air that these patients were getting.

Another improvement that has been realised from the project is that drop-in activity at the Skye Centre has been prioritized for any wards that are closed for part of the shift or the full shift. Prior to the introduction of the 0830 huddle this information was not discussed in detail.

The template is completed throughout the day by the Resource Administrator to give a full picture of the various factors that are impacting on the ward closure models. These templates can be used to provide evidence of the rationale behind decision making on a day to day basis together with the resources that have been made available.

Realistic Medicine

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

The six key themes of RM are:
1) Building a personalised approach to care
2) Changing our style to shared decision making
3) Reducing harm and waste
4) Becoming improvers and innovators
5) Reducing unwarranted variation in practice and outcomes
6) Managing risk better

The Realistic Medicine Clinical Lead led a Seminar Series on Realistic Medicine in March to raise awareness of the approach and engage staff across TSH in the principles of Realistic Medicine. An update was also provided to the Clinical Governance Group. The action plan is currently being reviewed with a requirement to submit to Scottish Government in May. The purpose of the action plan is to demonstrate how TSH is achieving traction for the principles of Realistic Medicine and value based Health and Care. Scottish Government has confirmed its continued support for Clinical Lead and Project Manager funding for 2023/24.

Evidence for Quality

National and local evidence based guidelines and standards

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

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies and reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 February 2023 to 31 March 2023, 32 guidance documents have been reviewed. There were 27 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 5 documents which were recorded for information and awareness purposes.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	2	2	0
Healthcare Improvement Scotland (HIS)	5	2	0
National Institute for Health & Care Excellence (NICE)	25	1	0

As at the date of this report, there are currently an additional 3 evaluation matrices nearing the end of the review process.

Table 3: Evaluation Matrix Current Situation

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
NICE	Self Harm: Assessment, management & preventing recurrence	MHPSG	Evaluation matrix required. Issues re availability addressed by MHPSG Chair in Jan 2023. Review arranged for 9 Feb 2023. Meeting to finalise review arranged for 19 Apr 2023.	Sept 2022	May 2023
Royal College of Psychiatry	Supporting mental health staff following the death of a patient by suicide: A pre & postvention framework	MHPSG	Forwarded to Clinical Quality by a medic to consider for review. MHPSG to review. Responses requested from sub group by 15 Feb 2023. Meeting to finalise review arranged for 19 Apr 2023.	Dec 2022	May 2023

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
SIGN	Pharmacological management of migraine	Medicines Committee	Review meeting arranged for 3 Feb 2023. Review completed with 100% compliance achieved. To be tabled at next Med Committee in May 203 for final agreement and sign off	Sept 2022	Apr 2023

There are currently 5 additional evaluation matrices, which have been outstanding for a prolonged period and await review by their allocated Steering Group. The progress of the first two evaluations from HIS and the MWC was temporarily paused due to TSH adapting to the COVID-19 pandemic however as per Gold Command, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group, which recommenced meetings in September 2020. Work is progressing with both, with an anticipated completion date of summer 2023.

The review of the Public Health England guideline was unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the review meeting and delay in members submitting feedback responses. This was flagged up for review as a matter of urgency upon the appointment of the Supporting Healthy Choices Project Officer. The gap analysis has been updated and still requires to be reviewed by the group however the Project Officer has now stepped down from this role and further guidance is awaited.

The Rehabilitation after Traumatic Injury guidance from NICE is currently approaching the end of the review process – it should be noted that this is a fairly comprehensive document and as such, an amended review process is being followed in order to reduce the time required by all MDT members involved.

The final guidance review regarding MS has temporarily been placed on hold pending diagnostic investigations being conducted on 1 patient. The GP and Practice Nurse are aware of the content of the guideline however feel it would be more prudent to work through the content in tandem with the investigation process given that there has been no previous history of any patient with this diagnosis.

Table 4: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
HIS	From Observation to Intervention: A proactive, responsive & personalised care & treatment framework for acutely unwell people in mental health care	Patient Safety	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Evaluation matrix being updated as draft Clinical Care Policy is now currently under consultation phase.	Jan 2019	Summer 2023
MWC	The use of seclusion	Patient Safety	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Care Policy currently under consultation with seclusion tier 1 and 2 being incorporated. Both to be launched together.	Oct 2019	Summer 2023

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
PH England	Managing a healthy weight in adult secure services - Practice guidance	Supporting Health Choices (SHC)	Unable to be completed within the tight deadline set by SHC group due to poor attendance at review meeting & delay in members submitting feedback (May 2021) prior to group being paused. Documents provided to newly appointed SHC Project Officer in order to progress this and obtain an outcome (Jan 2023). Matrix updated (Mar 2023) though still requires review & agreement of content by SHC group. SHC Project Officer no longer in post.	Feb 2021	Apr 2023
NICE	Rehabilitation from Traumatic Injury	PHSG	After being considered not relevant to TSH setting, decision was changed & evaluation matrix was required (Apr 2022). Due to large number of recommendations, review process was split into 2 parts: Part 1 - reviewed by AHP/Manual Handling Advisor (commenced June 2022 & completed Dec 2022) & Part 2 - wider multi-disciplinary review. Part 2 review commenced Jan 2023 with deadline of 3rd Feb 2023. Awaiting Psychology feedback as at Mar 2023 in order to complete	Jan 2022	Mar 2023
NICE	Multiple sclerosis in adults: Management UPDATED	PHSG	Previously reviewed in Oct 2014 when recorded for information purposes only. Given that TSH had no patients with an MS diagnosis PHSG agreed that should this change, the guideline would be used. Current 2022 situation was same however there is now 1 possible diagnosis pending with patient on waiting list for further investigation. Completion of matrix placed on hold until outcome	June 2022	2023 Awaiting outcome from specialist referral (March 2023)

The State Hospital Staff Resource Huddle – 0830 (Monday to Friday)

Date: **RAG Status:**

Operating Model:

Shortages on:
Day shift:
Back shift:
Night Shift:

Outings (number and staff required for these):

Tribunals:

Training:

Assistance from other disciplines:

Ward closures over last 7 days (to be populated prior to 8.30am meeting):

	Arran 1	Arran 2	Iona 1	Iona 2	Iona 3	Lewis 1	Lewis 2	Lewis 3	Mull 1	Mull 2
Closed for full shift										
Closed for part of shift										

Wards being closed on day shift:

Ward	**Rationale for choosing this ward**
Arran 1	
Arran 2	
Iona 1	
Iona 2	

Iona 3	
Lewis 1	
Lewis 2	
Lewis 3	
Mull 1	
Mull 2	

Wards being closed on back shift:

Ward	**Rationale for choosing this ward**
Arran 1	
Arran 2	
Iona 1	
Iona 2	
Iona 3	
Lewis 1	
Lewis 2	
Lewis 3	
Mull 1	
Mull 2	

Appendix 2

7th April 2023

Staff in attendance:

Lead Nurse	SCN	Business Manager	Skye Centre	Psychology	PCIT	Staff Nurse	Clinical Quality	AHP	Patient Moves

Operating Model:	**Shortages at 0830:**	**RAG Status at 0830:**	**Shortages at 1400:**	**RAG Status at 14:00:**
Day Shift:	Day Shift:	Day Shift**:**	Day Shift:	Day Shift**:**
Back Shift:	Back Shift:	Back Shift:	Back Shift:	Back Shift:
Night Shift:	Night Shift:	Night Shift:	Night Shift:	Night Shift:

Outings:	**Tribunals:**	**Visits:**	**Admissions:**	**Health Centre**
Number:	Number:	Number:	Number:	Number:
Ward:	Ward:	Ward:	Ward:	Ward:
Staff Needed:	Staff Needed:	Staff Needed:	Staff Needed:	Staff Needed:

Ward closures over last 7 days (to be populated prior to 8.30am meeting):

C: Closed for full shift P: Closed for part of shift M: Modified D: Not able to respond

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

	D	B	N	D	B	N	D	B	N	D	B	N	D	B	N	D	B	N	D	B	N
Arran 1:																					
Arran 2:																					
Arran 3:																					
Iona 2:																					
Iona 3:																					
Lewis 1:																					
Lewis 2:																					
Lewis 3:																					
Mull 1:																					
Mull 2:																					

D=dayshift, B=Backshift, N=nightshift

DAY SHIFT:

Assistance from other disciplines:

Nursing	
Skye Centre	
PCIT	
Psychology	
AHP	
CSLM	
Other	

BACK SHIFT:

Assistance from other disciplines:

Nursing	
Skye Centre	
PCIT	
Psychology	
AHP	
CSLM	
Other	

Wards impacted on day shift:

Ward	*Rationale for choosing this ward*
Arran 1	
Arran 2	
Arran 3	
Iona 2	
Iona 3	
Lewis 1	
Lewis 2	
Lewis 3	
Mull 1	
Mull 2	

Wards Impacted on back shift:

Ward	*Rationale for choosing this ward*
Arran 1	
Arran 2	
Arran 3	
Iona 2	
Iona 3	
Lewis 1	
Lewis 2	
Lewis 3	
Mull 1	
Mull 2	

Projection Next 24hrs:

Outings:	**Tribunals:**	**Visits:**	**Admissions:**	**Health Centre**
Number: Ward: Staff Needed:	Number: Ward: Staff Needed:	Number: Ward: Staff Needed:	Number: Ward: Staff Needed:	Number: Ward: Staff Needed:

Staffing Deficits Tomorrow:

	AM	**PM**	**ND**

Arran 1:			
Arran 2:			
Arran 3:			
Iona 2:			
Iona 3:			
Lewis 1:			
Lewis 2:			
Lewis 3:			
Mull 1:			
Mull 2:			
Total:			

Assistance from other disciplines:

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM

Minutes of the Clinical Forum held at 10.00am on Tuesday 17 January 2023 via Microsoft Teams

Chair:	
Dr Sheila Howitt	Consultant Forensic Psychiatrist
Present:	
Josie Clark	Lead Professional Nurse Advisor
Lindsey MacGregor	Lead Allied Health Professional
Apologies:	
Dr Aileen Burnett	Consultant Clinical Psychologist
Ben Green	Clinical Liaison Security Manager
Dr Jana de Villiers	Consultant Psychiatrist
In Attendance:	
David Hamilton	Social Work Team Leader
Sheila Smith	Head of Clinical Quality
David McCafferty	PA to CEO/Chair (Minutes)
Nicola Watkins	Lead Pharmacist

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

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

NOTED.

2 CONFLICT(S) OF INTEREST

The Chair confirmed there were no conflicts of interest.

AGREED.

3 APPROVAL OF PREVIOUS MINUTES

The minutes of the previous meeting held on 29 November 2022 were approved as an accurate record.

APPROVED.

4 URGENT MATTERS ARISING

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

NOTED.

5 REVIEW OF ROLLING ACTIONS LIST

The Forum received the action list and noted progress on the action points from the last meeting. The remainder of actions were completed or on today's agenda for discussion.

NOTED.

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

The Clinical Forum Vice Chair advised members that key items of discussion at the last meeting of the Area Clinical Forum Chair's Group included;

- Staffing pressures currently experienced across all Boards. Meeting was noted to have been a supportive session with nil of concern required to be fed back through this group.

NOTED.

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

(a) Nursing and Allied Health Professions Advisory Committee

Members noted the meeting scheduled for 20/12/22 did not take place. Current weekly pressures were highlighted to the group along with challenging nursing starting positions noted to be attributed to staff sickness-absence numbers. AHP vacancies were noted to be filled on an ongoing basis. Gender mix policy and Clinical Model were both agenda items for discussion at the next meeting.

NOTED.

(b) Medical Advisory Committee

Members received and noted the minute of the Medical Advisory Committee which took place on 12 December 2022. Key discussions included implementation of face-to-face CTM Meetings, CPA Meetings were now in person. Patient illicit substance use results were discussed and the related numbers of false-positive results. Clinical Model update was discussed and the Medical Director's report. Women's Forensic Planning Group were due to meet on 15th February 2023. Issue noted around supply of PANSS forms to junior doctors and a solution was being sought.

NOTED.

(c) Psychology Professional Practice Meeting

Apologies were received from psychology representation for today's meeting. Mr McCafferty would contact Dr Aileen Burnett to ascertain if the meeting took place and to provide the group with any relevant update via email.

ACTION – DAVID MCCAFFERTY (COMPLETE 26/01/23) – Paper circulated 24/02/23

NOTED.

(d) Update Report from Dentist, GP and Optometric

Members received and noted the November 2022 to January 2023 update in relation to the Dentist, GP and Optometric Services. The Health Centre was noted to be functioning well. Move was underway to look at overall patient referrals numbers outwith the hospital and the available resources related to supporting this.

NOTED.

8 UPDATE ON CLINICAL MODEL

Members were provided with a verbal update on progression of the Clinical Model by Dr Sheila Howitt, as Clinical Lead. Dr Howitt advised that the Clinical Model Project Team continued to meet weekly. Project Oversight Board and Clinical Model SLWG continued to meet monthly. Clinical guidance noted to be the focus of the current work stream - second drafts were to be finalised by end of January 2023. Patient mapping was underway alongside the planning process for patient transitions including plan for staffing. Workforce guidance meeting was planned to develop the process - chaired by HR. Contingency planning discussions were noted to be underway. Implementation was planned for end of March 2023. A further update to this group expected at the next Clinical Forum Meeting in March.

NOTED.

9 FORUM 2023 WORKPLAN

Members discussed and reviewed the Forum's 2023 Workplan. Mr McCafferty would arrange for Head of Planning and Performance to attend the Clinical Forum in March 2023 to provide an overview of the Annual Operational Plan of the NHS Board.

ACTION: DAVID MCCAFFERTY (COMPLETED 26/01/23)

NOTED.

10 AOCB

There were no other items of business brought for discussion at this meeting.

11 DATE AND TIME OF NEXT MEETING

The next meeting of the Clinical Forum would take place at 10am on Tuesday 21 March 2023 via Microsoft Teams.

Meeting concluded at 1045 hours

Paper No 23/27

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 April 2023
Agenda Reference:	Item No: 14
Sponsoring Director:	Director of Workforce
Author(s):	HR Advisor / Training & Professional Development Manager / Head of HR
Title of Report:	Staff Governance Report
Purpose of Report:	For Noting

1 SITUATION

This report provides an update on overall work within the Workforce Directorate. This report encompasses all the updates in one rather than the numerous papers in the past.

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

2 BACKGROUND

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

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

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

3 ASSESSMENT

HR UPDATE

- **Absence and Attendance Management**

- The absence rate for March 2023 was 9.14% (February 2023 was 8.81%). The rolling year average is 7.45%.
- Within Nursing, the absence rate for March 2023 was 11.39% (February was 12.10%). The rolling year average is 9.45%

- The HR team continue to support line managers to offer guidance to plan for every member of staff who requires long-term sickness review meetings. This can be planning for a return to alternative duties as soon as appropriate and possible, considering alternative employment or supporting an exit from the organisation.
- 98 staff were being managed through the formal stages of the Attendance Policy and 24 staff were off on long-term absence.
- Key reasons for short-term absence were anxiety/stress/depression, cold/cough/flu, chest / respiratory problems, back problems, injuries/fractures and gastrointestinal.
- Key reasons for long-term absence, were anxiety/stress/depression, musculoskeletal, injury / fracture and back problems.
- Covid related absence increased during March and accounted for 2.25% of all absence.
- Detailed work continues to be undertaken in targeted departments looking at trends and patterns of absence, using this information to identify what supports can be put in place to support individuals in remaining at work as well as supported back to work from absence.
- There have been 23 staff at Stage 1 Attendance Management meetings in March 2023 and 1 staff at Stage 2.
- Supportive guidance has been issued to line managers to ensure that return to work interviews are of a high quality and are conducted timeously following a period of absence as we know these are indicators for reducing repeated absence.
- Training is being developed for line managers jointly with the Trade Union, covering the range of issues which arise in maximising attendance at work beyond the terms of the policy for example being person centred, using good judgements and acting reasonably throughout. A face to face attendance training session will take place on 25 May 2023. Charge Nurse Return to Work training has also been developed and a date for training is to be confirmed.
- We are currently introducing eRostering throughout the Hospital which will give us an additional mechanism to capture sickness absence. This system will enable pattern to be identified such as sick leave at the weekend, after pay day and before/after annual leave. This will help with the discussions between the Manager and Staff who are able to easily identify these patterns and challenge any issues.
- The HR Assistant post has now been filled with a start date of 8 May 2023. This will allow the release the current post holder to their new role of Assistant HR Advisor and initially prioritise support to operational managers around attendance management. A planning session is scheduled to agree key priorities for this role.
- Sessions with the Business Disability Forum have taken place regarding reasonable adjustments in our workplace. There was good attendance from the HR team and Managers from the service (x12 on the third Q&A session). Further work planned to link with colleagues in similar organisations in England and then the development of guidance for TSH.

- **Occupational Health**

NHS Dumfries & Galloway commenced their new SLA from 1 April 2023. Prior to commencing they attended a number of meetings and also held an open meeting in the Wellbeing Centre which was well attended.

The Team are planning to quickly develop an Action Plan of the work they plan to undertake with timescales. They also wish to provide service within the Hospital / Hubs to maximise support for Managers and Staff and consider the future provision of the services based on the need.

- **Recruitment**

- 5 separate posts were advertised in March for 5 vacancies.
- There are 3 individuals with confirmed start dates and a further 22 with conditional offers pending checks and clearances.
- Work is ongoing to consider the KPI for recruitment to ascertain how the timelines can be reduced. There are four areas of note where the TSH figure is significantly above the KPI
- Advert Live to Closing Date KPI is 10 days. TSH timescale was 17 days. This was due to a number of hard to fill posts having extended closing dates.
- Closing date to Shortlist complete KPI is 5 days. TSH timescale was 3 days. This has improved since January due to a focus on reminding hiring managers via email to complete within 5 days of advert closing.
- Invite to Interview to Interview date KPI is 7 days. TSH timescale is 15 days. This is due to the timescales taken by hiring managers to provide a date for interview. Best practice would be for hiring managers to have an interview date stated within candidate advert which would improve this KPI. Focused work is being undertaken with recruiting managers to encourage setting an interview date at advertising stage. This has improved since February's data by 6 days.
- Following endorsement at Partnership Forum and CMT, a Short Life Working Group has been set up to update the Board's Recruitment Strategy and approach to retention, taking account of the information with Exit Interviews. Membership of this group consists of Trade Unions, Managers, HR, Learning & Development and also employees who have recently joined the organisation.
- 18 Staff Nurses are progressing through pre employment checks. Lead Nurses have been asked to ensure there is communication from nursing managers throughout to ensure new staff are supported from the outset. This was an area of improvement required from the recent onboarding survey results.
- The trial / test of change remains in place via MS Forms where new employees are contacted for feedback regarding their on-boarding experience. This has now been expanded to request additional feedback for staff at 6 months. A 12 months post-employment survey is currently in development and should be ready to issue mid April.

- **Turnover**

- 5 staff ended their employment at The State Hospital in March 2023. This brings the total number of staff who have left within financial year 2022/23 to 88 to date.
- It should be noted that 16 of the 88 staff who have been terminated have returned as part of the Nursing Pool to SSR activity.
- Also three of those who left were due to the end of a Fixed Term Contract.

- One staff member withdrew their notice after their termination was submitted, which was accepted.
- Exit interviews are offered to all staff on leaving the organisation. The test of change remains in place enabling staff who are leaving to complete the exit interview through this function. Staff are given both the link and a QR code to access this. 11 individuals have completed the exit form in this way to date, providing useful information. Analysis continues to be conducted and work will continue within the scope of the recruitment and retention short life working group.

- **Supplementary Staffing**

- 45.82 WTE supplementary staffing were required through overtime or excess hours for the whole organisation. 30.41 WTE supplementary staffing were required for Nursing.
- Work will be overseen by the Workforce Governance Group on analysing the use of overtime / excess hours and supplementary staff.

- **3- year Workforce Plan Update**

Work is ongoing on the Actions from this Plan with this being reported to the WGG. We are also commencing review of this in terms of what has moved forward since the plan was developed in terms of age profile / gender mix / recruitment issues and will also be reported to WGG then onwards to CMT.

- **Employee Relations**

- There are 4 ongoing cases, 2 of which have been ongoing for more than 6 months and timescales have been agreed for progressing these to completion as soon as possible.
- Focus remains on quality early resolution for employment relations cases where appropriate.
- The CLO Employment Team is offering a briefing session to Managers on 21 April 2023 in the Seminar room, Harris, from 1 to 2 pm. The session will cover lessons learned from Employment Tribunal cases that the CLO team have dealt with recently this will cover the following areas: Recruitment, Worker Status and Investigations. There will also be the opportunity to ask any questions about any employment law issues.

- **eRostering**

  eRostering is well underway and Teams are currently going over their rosters with a view to switching them all on and this will be done by mid-May. There is 4 stages to the implementation which are Initiation, Readiness, Deployment, Adoption and Realisation. We are currently in Deployment and will move to Adoption in May before moving to Realisation where we will start to use the roster information to improve service delivery across all areas.

Some of the agreed national benefits to this programme will be delayed to due to the national work on providing Boards with an interface between eRostering and SSTS which is planned for July at the moment.

The introduction of this new system offers up an opportunity for data to be analysed and viewed at a glance by the Line Managers. They will be able to see any set patterns and highlight this to staff. This includes absence after pay day, weekend absence, public holiday absence or indeed absence just prior to or after a period of annual leave. This will enable Managers to consider areas of concern.

Learning, Training & Development

- **PDPR Compliance**

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

As at 31 March 2023:

- The total number of current (i.e. live) reviews was 487 (80.8%) – a decrease of 4.3% from February 2023.
- A total of 98 staff (16.3%) had an out-of-date PDPR (i.e. the annual review meeting is overdue) – an increase of 5.3% from February 2023.
- A further 18 staff (2.9%) had not had a PDPR meeting – a decrease of 1% from February 2023. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

There are currently 13 departments below the State Hospital's 80% minimum compliance threshold (an increase of three from last month). This includes:

- AHP – compliance level 77.8% - with 2 reviews overdue. Non-compliant from 31 March 2023.
- Arran 1 – compliance level 73.3% - with 8 reviews overdue. Non-compliant from 31 March 2023.
- eHealth – compliance level 69.2% (no change – with 1 review overdue and 3 staff with no review/PDP). Non-compliant for 18 months.
- Estates – compliance level 36% - with 14 reviews overdue and 2 staff with no review/PDP. Non-compliant from 31 March 2023.
- Executive Director Reports – compliance level 50% (decreased 4.2% - with 9 reviews overdue and 3 staff with no review/PDP). Non-compliant for 18 months.
- Finance – compliance level 60% - with 2 reviews overdue. Non-compliant from 31 March 2023.
- Health Records – compliance level 66.7% (no change – with 1 review overdue). Non-compliant for 3 months.
- Hub Admin & PAs – compliance level 25% (decreased 22.8% - with 15 reviews overdue and 3 staff with no review/PDP). Non-compliant for 6 months.
- Lewis 2 – compliance level 70% (decreased 7.4% - with 8 reviews overdue and 1 staff member with no review/PDP). Non-compliant for 2 month.
- Nurse Practice Development – compliance level 66.7% - with 1 review overdue. Non-compliant from 31 March 2023.

- Nursing Pool / SSR – compliance level 75% (increased 17.9% - with 1 review overdue). Non-compliant for 1 month.
- Psychology – compliance level 66.7% (decreased 5.5% - with 5 reviews overdue and 1 staff member with no review/PDP). Non-compliant for 3 months.
- Security Liaison – compliance level 77.8% (with 2 reviews overdue). Non-compliant for 1 month.

Progress reports continue to be provided to all departmental managers on a monthly basis, and compliance levels are monitored and reviewed quarterly by the Organisational Management Team.

iMatter

The 2023 iMatter cycle will commence as follows:

- 24 April - Team confirmation begins
- 22 May - Questionnaire distributed to workforce
- 26 June - Team reports are published
- 22 August - Team action plan completion date

The 2023 questionnaire will feature additional questions to capture whistleblowing concerns. These questions will not impact on the employee engagement index (EEI) but run as a test of change for 2023 with appropriate evaluation of success and impact.

Coaching

There are three internal trained coaches who provide coaching for TSH workforce and work as part of a collaborative coaching network across the West of Scotland.

- We have three members of TSH staff being coached internally by TSH coaches.
- We have one TSH member of staff waiting to be matched by a NHSL coach.
- We have one external NHS staff member being coached by a TSH coach.

Coaching for Wellbeing continues to be available for all H&SC staff across Scotland and registration for this can be accessed via the National Wellbeing Hub.

Team Development

Affina Team Journey - two teams are currently engaged with this development programme. Core Strengths SDI 2.0 - one group of staff are currently engaged with this team development tool and this is also a feature of the current Charge Nurse Development programme.

Wellbeing

Funding approval is now in place for the Wellbeing Advisor post and the SLA with NHS Lanarkshire for the Staff Care Specialist role to continue on permanent basis. Although this will remain as a cost pressure to the Board, this highlights the ongoing support of providing ongoing services for Staff Wellbeing within the TSH and build on the successes to date. Unfortunately the Staff Care Specialist has now left the organisation for a permanent role however NHS Lanarkshire are committed to providing ongoing support as part of their SLA and 2 new Staff Care Specialist will assist. Graeme Bell and Patricia Johnston have commenced and had a full case handover from Lorna prior to her leaving to ensure as

smooth a transition as possible. They will cover on a temporary basis until the post is advertised and recruited to for the 2 days per week support from NHS Lanarkshire.

Staff, volunteers and visitors continue to access the Wellbeing Centre regularly on a daily basis.

The Wellbeing Team are continuing with wellbeing check-ins/visits across all departments, especially to areas where staff find it difficult to access the Wellbeing Centre.

Q1: 9 visits across wards and Skye centre
Q2: 0 (due to restrictions around infection control)
Q3: 11 visits across wards and Skye centre
Q4: Coffee, Cake & Conversation events have been a great success with Managers feeling more able to release staff for a short period of time. Overall, 123 staff have attended the events.

Mull – 02/02/23 = 8 staff attended
Iona – 03/02/23 = 13 staff attended
Staff Dining Room – 09/02/23 = 20 staff attended
Wellbeing Centre – 10/02/23 = 25 staff attended
Arran – 24/02/23 = 16 staff attended
Lewis – 16/03/23 = 17 staff attended
Security – 16/03/23 = 8 staff attended
Skye Centre – 17/03/23 = 16 staff attended
MS Teams – 17/03/23 = 0 staff attended
Evening event – to be arranged
Weekend event – to be arranged

As the Coffee, Cake and Conversations has gone so well, the Team plan to undertake a further round of these in conjunction with the team from OH.

The Peer Support Network training is well underway with 22 staff applying to attend the training and become a peer supporter. Not all applicants are suitable and it anticipated that approximately 12 staff will be trained by June 2023.

To date, the Staff Care Specialist has received a total of 52 referrals for support. Whilst retaining confidentiality, it is hoped that key themes coming from these discussions can provide information on the improvements and services moving forward

Three of six training sessions for 'Supporting a Mentally Healthy Workforce Training for Managers and Leaders' held to date – 20 managers have attended so far. Further training dates have been planned in the 2023/24 training calendar.

Staff benefit programmes currently being formulated:

- Cycle to Work Scheme – ready to launch in April 2023.
- NHS Credit Union – online sessions and marketing for all as well as targeting different staff groups i.e. new starts, retirees, offline staff

4 RECOMMENDATION

Board members are invited to note this report and the updates.

MONITORING FORM

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

Paper No 23/28

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 April 2023
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Quarter 4 Update and Whistleblowing Standard Annual Report – 2022/23
Purpose of Report:	For Decision

1 SITUATION

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

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

2 BACKGROUND

The SPSO (Scottish Public Services Ombudsman) developed a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services and this was formally published on 1 April 2021. The Independent National Whistleblowing Office (INWO) provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing case. For NHS Scotland staff, these form a 'Once for Scotland' approach to Whistleblowing.

3 ASSESSMENT

The Quarter 4 update is from 1 January 2023 to 31 March 2023. No formal Whistleblowing cases were raised during this quarter either direct to The State Hospital or indirect via the INWO.

In the performance year 2022/23, the State Hospitals Board for Scotland had no cases raised under Whistleblowing. This Annual Report details the work undertaken to develop the processes within the Board and the Actions following the previous investigations and the subsequent Action Plan.

4 RECOMMENDATION

Staff Governance are asked to approve the Whistleblowing Annual Report for 2022/23 which will be sent to the INWO and published on the Internet site.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

WHISTLEBLOWING ANNUAL REPORT

1 April 2022 – 31 March 2023

1. INTRODUCTION

The SPSO (Scottish Public Services Ombudsman) developed a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services and this was formally published on 1 April 2021. The Independent National Whistleblowing Office (INWO) provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing case. For NHS Scotland staff, these form a 'Once for Scotland' approach to Whistleblowing.

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

In addition to this, the Scottish Government revised and promoted the role of the Whistleblowing Champion as a formal Non-Executive member of each NHS Board. Their role is to ensure that the systems are in place to enable staff to raise concerns, and that the culture of the organisation supports the full application of these systems, by valuing staff concerns. Unfortunately, this post remained vacant until December 2022 when our new Non-Executive for Whistleblowing was confirmed by the Cabinet Secretary. It should be noted however during this time, it was agreed by the Board that staff would be able to raise concerns with any of the Non-Executive Directors

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

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

This is the second Annual Report and is for the reporting activity from 1 April 2022 until 31 March 2023.

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

2. BACKGROUND

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

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

As part of the process to implement the new National Whistleblowing Standards, following concerns raised during 2021/22, an Action Plan was developed by the HR & Wellbeing Group and continues to report to Partnership Forum, Corporate Management Team, Staff Governance Committee and the Board. This Group will continue to co-ordinate and support implementation of the Action Plan, ensuring HR policy and process implementation, training and communications are fully met. Delivery of this Action Plan is fully supported by the all members of the Board who play a role in ensuring communication and development of the action in line with the Standard.

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

The current Whistleblowing Champion is the Director of Workforce. The Whistleblowing Champion has been proactive in engaging with the organisation and raising awareness of the Standards and in providing critical oversight of governance mechanisms for reporting on and dealing with Whistleblowing concerns, to complement the oversight provided by the Board.

3. CONCERNS RAISED

Since 1 April 2022 to 31 March 2023 there was no Whistleblowing concerns raised direct to the Board.

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

However, there was one anonymous complaint received by the INWO during Quarter 3, which they have reported to us. They have confirmed that this is for our noting and no further action will be taken by them or any expectation on actions from the Board.

4. ACTIONS

Since the implementation of the standards, The State Hospital have continued to consider how best to provide continuous improvement in processes and support to any individual raising concerns.

An Action Plan was developed in line with the outcome of Whistleblowing Concerns raised during 2021/22 and reported in the previous report. Key themes which were raised from the previous investigations included:

- Review of Recruitment Processes;
- Work on building key relationships to ensure openness and transparency;
- Further communications on the Whistleblowing Standards and Training;
- Development of more Confidential Contacts;
- Recruitment to the Non-Executive Whistleblowing Lead;

- Development of an internal Operating Procedure providing clarity on the process followed when dealing with any concerns;
- Additional support sources, not only for those who are raising the concerns but for anyone who may become involved (i.e. witnesses)
- Development of a Communication Plan aimed at raising awareness of the Standards;
- Development of a Culture where complaints and concerns are encouraged and welcomed.

These learning points form part of the Action Plan, which is considered at the HR & Wellbeing Group and updated to the Staff Governance Committee and Board.

The State Hospital participated in the "Speak up Week" which took place on 3-7 October 2022. Staff Bulletins were circulated to the service with updates from a number of contributors including the Chair, Chief Executive and Employee Director. Noticeboards provided information to staff on the Standard and the main one was placed in the front reception area. This also provided staff with specially branded pens, notepads and post-it notes, highlighting that "Speaking up is in everyone's interest". A Wordsearch competition was also undertaken and the winner of a Fitbit watch was a Catering Assistant. Information relating this to initiative was also highlighted on social media and general feedback to this initiative has been positive.

The INWO attended a Board Development Session in September 2022 with Executive and Non-Executive members. They provided a presentation on the Standards and expectations of the Board along with an opportunity for questions. This was extremely helpful for those present to understand their role in the Standard.

Work continues on highlighting the requirement for Staff and Managers to complete the on-line module on the Whistleblowing Standards and update to date is:

Introduction for all Staff – 356 (83% of target group)
Managers Training – 68 (68% of target group)

6. FUTURE ACTIONS

Work continues on this standard and ensuring continued areas of improvement, which include:

- Developments of the Confidential Contacts, which includes discussions with other National Boards to support this agenda, ensuring complete confidentiality at all stages.

- Clarity and continued development of the role of the Investigating Manager. This includes development of a Standard Operating Procedure. This Operating Procedure would provide clarity regarding how a Whistleblowing complaint will be dealt with from initial receipt until the closure of a case, the sharing of lessons learned and service improvements made as a result of a concern being raised. The internal Operating Procedure should also outline a process for distinguishing between a Whistleblowing complaint and other HR concerns such as Bullying & Harassment and Grievances and should address issues such as anonymity, confidentiality and ongoing feedback and communication whilst a case is being investigated

- Communications on the new Non-Executive Whistleblowing Champion, with information on the future of the Standards and support for staff.

- Further development of a Culture where complaints are encouraged and welcomed by Management

7. REPORTING

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

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

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

Annual Report 2021/22 Approval	-	23 June 2022
Quarter 1 Update	-	25 August 2022
Quarter 2 Update	-	22 December 2022
Quarter 3 Update	-	23 February 2023
Quarter 4 and Annual Report Approval	-	27 April 2023

8. QUALITY AND PATIENT CARE

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

7. CONCLUSION

Although there was no formal cases raised via Whistleblowing, Actions continue on previous issues raised and work will continue on improving the work on the Standard. This will thereafter encourage staff to raise their concerns in a safe and secure environment.

The State Hospitals Board for Scotland
27.04.2023

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 April 2023
Agenda Reference:	16
Sponsoring Director:	Finance & eHealth Director
Author(s):	Finance & eHealth Director
Title of Report:	Annual Review of Standing Documentation
Purpose of Report:	For Decision

1 SITUATION

This report provides an update to the Board on proposed changes to Standing Documentation covering updated policy and minor updates to job titles.

2 BACKGROUND

The Board is required annually to review and approve updates to Standing Documentation i.e. Standing Financial Instructions, Scheme of Delegation and Standing Orders (covered under a separate Committee paper) – these changes having received prior approval from the Audit Committee's April meeting, from which recommendation was made that the updates be approved.

3 ASSESSMENT

3.1 Standing Financial Instructions

There are no major amendments noted nor required – these having been fully updated in 2022 to reflect updated legislation and procurement regulations post-EU, updated tender thresholds to comply with Procurement Act 2014, updated tender waivers from £5k to £10k (last update 2016) and updated TSH Procurement Policy.

3.2 Scheme of Delegation

There are amendments noted to clarify approvals required for Service Level Agreements (s14.9), and to remove historic reference to sealing of documents.

4 RECOMMENDATION

The Board is asked to approve the review of Standing Documentation, as recommended by the Audit Committee.

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 portfolios.
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Finance & eHealth Director, Head of Procurement, Deputy Finance Director Audit Committee (April 2023)
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ **There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

SCHEME OF DELEGATION

VERSION 1~~7~~5

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

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

17	April 2023	Amended section 14.9 to clarify inclusion of SLAs Removed historic reference to sealing of documents Approved by Audit Committee 6 April 2023 For approval by Board 27 April 2023

1. DELEGATION OF POWERS

1.1 Delegation to Committees

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

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

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

2. SCHEME OF DELEGATION TO OFFICERS

2.1 Role of the Chief Executive

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

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

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

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

2.2 Caution over the Use of Delegated Powers

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

2.3 Directors' Ability to Delegate their own Delegated Powers

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

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

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

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

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

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

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

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

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

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

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

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

THE STATE HOSPITALS BOARD FOR SCOTLAND
SCHEME OF DELEGATION

1. Organisational Scope / Profile

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

2. Corporate Governance

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

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

4. Planning and Performance

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

5. Risk Management

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

6. Clinical Governance

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

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

7. Equality & Involvement

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

8. Access, transfer, referral, discharge

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

9. Healthcare Associated Infection

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

10. Health Promotion and Education

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

11. Information Management

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

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

12. Staff Governance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Contract value over £250,000	Chief Executive	N/A N/A	N/A	Approval to proceed with tender process

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

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

STANDING FINANCIAL INSTRUCTIONS

VERSION 19~~6~~

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

14	March 18	Updated section 2.6.2 to reflect depute Accountable Officer as being Nursing & AHP Director and not Finance Director. Updated section 3.6 to change Monitoring Returns to Financial Performance Returns. Updated section 5 in relation to Project Bank Accounts. Updated section 9.6 to reflect that payments to employees would be by bank credit only. Updated section 13.1.1 to include reference to General Data Protection Regulations. Updated section 16.1.10 to include new rules imposed in October 2017 around patient gambling. Approved by Audit Committee 5 April 2018. Approved by Board 28 June 2018
15	March, May 2019	Updated references to Local Delivery Plan – amended to Annual Operational Plan Updated section 5.3.2 – reflect requirement of two directors' signed authorisation to open any bank account in the name of the Hospital Removed section 17 – Funds held in Trust – no longer applicable to the Hospital with no endowment funds in place Approved by Audit Committee 28 March 2019. Approved by Board 20 June 2019
16	March 2020	Amended wording re secondment of HR Director (1.3.15) Approved by Audit Committee 26 March 2020 Approved by Board 18 June 2020
17	March 2021	Updated references to Annual Operational Plan – amended to Remobilisation Plan Updated job titles Approved by ~~To~~ Audit Committee 25 March 2021 Approved by Board 17 June 2021
18	March 2022	Updated sections 10.2.7, 10.3.2 – removing EU reference, update re new Procurement Regulations Updated section 10.3.4,5 – update tender thresholds to comply with Procurement Act 2014, tender waiver from £5k to £10k (last update 2016) Updated section 10.3.10 – re new TSH Procurement Policy Updated section 10.4.1 – re new legislation Approved by Audit Committee 17 March 2022 Approved by Board 23 June 2022
19	March 2023	Updated section 6.2.3 – updated job title Approved by Audit Committee 6 April 2023 For Board approval 27 April 2023

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1 INTRODUCTION

1.1 General

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

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

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

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

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

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

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

1.2 Interpretation

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

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

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

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1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

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

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

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

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

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

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

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

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

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

1.3.10 The Finance Director is responsible for:

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

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

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

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

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

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

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

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

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

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

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

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2 RESPONSIBILITIES OF CHIEF EXECUTIVE AS ACCOUNTABLE OFFICER

2.1 Introduction

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

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

2.2 General Responsibilities

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

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

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

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

2.3 Specific Responsibilities

2.3.1 The Accountable Officer must:

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

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

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

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

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

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

2.4 Advice to the Body

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

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

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

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

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

2.5 Appearance before the Public Audit Committee

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

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

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

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

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

2.6 Absence of Accountable Officer

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

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

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

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

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

3.1 Preparation and Approval of the Financial Plan and Budgets

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

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

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

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

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

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

3.2 Budgetary Delegation

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

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

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

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

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

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

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3.3 Budgetary Control and Reporting

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

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

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

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

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

3.3.3 Each Budget Holder is responsible for ensuring that:

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

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

3.4 Cost Improvements and Income Generation

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

3.5 Capital Expenditure

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

3.6 Financial Performance Returns

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

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4 ANNUAL ACCOUNTS AND REPORTS

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

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

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

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

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

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

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

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

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

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5 BANK AND GOVERNMENT BANKING SERVICE (GBS)

5.1 General

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

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

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

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

5.2 Bank and GBS

5.2.1 The Finance Director is responsible for:

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

5.3 Banking Procedures

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

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

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

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

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

6.1 Income Systems

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

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

6.2 Fees and Charges

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

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

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

6.3 Debt Recovery

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

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

6.3.3 Overpayment when detected should be recovered.

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

6.4 Security of Cash, Cheques and Other Negotiable Instruments

6.4.1 The Finance Director is responsible for:

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

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

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

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

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

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

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

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

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

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7 CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

7.1 Capital Investment

7.1.1 The Chief Executive:

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

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

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

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

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

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

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

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

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

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

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

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

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

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7.2 Asset Registers

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

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

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

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

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

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

7.3 Security of Assets

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

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

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

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

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

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

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

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

7.3.8 Registers shall be maintained by the responsible officer for:

- Equipment on loan;
- Leased equipment.

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

7.4 Sale of Property, Plant and Equipment,

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

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

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

7.4.3 Managers must ensure that:

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

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8 SERVICE LEVEL AGREEMENTS (SLAs)

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

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

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

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

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

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9 TERMS OF SERVICE AND PAYMENT OF EXECUTIVE DIRECTORS AND EMPLOYEES

9.1 Remuneration and Terms of Service

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

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

9.1.3 The Remuneration Committee will:

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

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

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

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

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

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

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

9.2 Funded Establishment

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

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

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9.3 Staff Appointments

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

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

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

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

9.4 Contracts of Employment

9.4.1 The Human Resources Director will be responsible for:

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

9.5 Pay and Payroll Documentation

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

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

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

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

9.6 Processing of Payroll

9.6.1 The Finance Director is responsible for:

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

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9.6.2 The Finance Director will issue instructions regarding:

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

9.6.3 Appropriately nominated managers have delegated responsibility for:

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

9.7 Settlement Agreements, Early Retirement and Redundancy

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

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

9.8 Relocation Expenses

9.8.1 The Human Resources Director is responsible for:

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

9.9 Non Salary Rewards

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

- Cash bonuses
- Amenities and recreational facilities

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

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

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

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

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10 NON-PAY EXPENDITURE

10.1 Delegation of Authority

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

10.1.2 The Finance Director will identify:

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

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

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

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

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

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

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

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

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

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

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

10.2.4 The Finance Director will:

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

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

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

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

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

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

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

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

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

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

10.2.6 Official Orders must:

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

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

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

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

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

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

10.3 Tendering Procedures

10.3.1 The procedure for making all contracts by or on behalf of the Board shall comply with these Standing Financial Instructions.

10.3.2 ~~Directives by the Council of the European Union prescribing~~Public Contracts (Scotland) Regulations 2015 and the Procurement Reform Act Scotland 2014 ~~procedures~~ for awarding all forms of contracts shall have effect as if incorporated in Standing Orders and Standing Financial Instructions.

10.3.3 The Board shall comply as far as is practicable with the requirements of the "Scottish Capital Investment Manual". In the case of management consultancy contracts the Board shall comply as far as is practicable with SGHSCD guidance "The Use of Management Consultants by Scottish Health Authorities" (MEL (1994) 4).

10.3.4 Where the estimated value of the contract is £5~~1~~0,000 or greater (exclusive of VAT), ~~competitive~~ a regulated tender process will be carried out. Where the estimated value of the contract is between £5,000 and £50,000 a quotation process~~s~~ will be carried out and both processes will cover: ~~will be invited for:~~

- The supply of all goods, materials and manufactured articles not available to the Board through national contracts
- For the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the SGHSCD)
- For the design, construction and maintenance of building and engineering works

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(including construction and maintenance of grounds and gardens)
- For disposals of assets.

10.3.5 The Chief Executive and Finance Director may dispense with the requirements for competitive tendering or quotations if they jointly agree that it is not possible or desirable to undertake or obtain having regard for all the circumstances. Such decisions and their reasons must be recorded. Formal tendering procedures may be waived with the approval of the Chief Executive and Finance Director where:

a) The time scale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or
b) Specialist expertise is required and is available from only one source; or
c) The task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
d) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
e) The Product has been used within the hospital or other secure units and meets a security need. You must provide evidence of other similar products and the reason why these will not suit. (statement from Security Director is required)or
f) As provided for in the Scottish Capital Investment Manual.
g) The overall value of the contract exceeds £10,000 + VAT.

10.3.6 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

10.3.7 Where it is decided that competitive tendering is not applicable and should be waived by virtue of the above, the fact of the waiver and the reasons must be documented and reported by the Chief Executive to the Board in a formal meeting and recorded in a register kept for that purpose.

10.3.8 Except where 10.3.5 or a requirement under 10.3.2, applies, the Board shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate. This would normally comprise no less than three, firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

10.3.9 The Board shall ensure that normally the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Finance Director it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive. Suppliers shall normally be chosen in rotation from the list unless the approval of the Chief Executive or nominated officer is given.

10.3.10 Tendering procedures are set out in a separate Procurement Policy for Tendering and Contracting.~~Financial Operating Procedure.~~

10.3.11 Quotations are required where formal tendering procedures are waived under 10.3.5 a) or c) and where the intended expenditure or income exceeds, or is reasonably expected to exceed £5,000.

10.3.12 Where quotations are required under 10.3.4 they should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board.

10.3.13 Quotations should be in writing unless the Chief Executive or nominated officer

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determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

10.3.14 All quotations should be treated as confidential and should be retained for inspection.

10.3.15 The Chief Executive or nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

10.3.16 Non-competitive quotations in writing may be obtained for the following purposes:

a) The supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations
b) The goods/services are required urgently; and

c) Where tenders or quotations are not required, because expenditure is below £5,000, the Board shall procure goods and services in accordance with procurement procedures prepared by the Finance Director.

10.4 Contracts

10.4.1 The Board may only enter into contracts within its statutory powers and shall comply with:

a) Standing Orders
b) Standing Financial Instructions
c) ~~EU~~WTO GPA Directives and other statutory provisions
d) Any relevant directions including the Scottish Capital Investment Manual and guidance on the Use of Management Consultants (MEL(1994)4)
e) Such of the NHS Standard Contract Conditions as are applicable
f) ~~The key procurement principles set out in CEL 05(2012).~~Public Contracts (Scotland) Regulations 2015
g) Procurement Reform Act Scotland 2014

10.4.2 Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

10.4.3 In all contracts made the Board shall endeavour to obtain best value for money. The Chief Executive shall formally nominate an officer who shall oversee and manage each contract on behalf of the Board.

10.4.4 All contracts entered into by the Board shall contain clauses, standard examples of which are detailed in the Procurement Policy, empowering the Board to:

a) Cancel the contract and recover all losses in full where a company or their representative has offered, given or agreed to give, any inducement to Board staff
b) Recover all losses in full or enforce specific performance where goods or services are not delivered in line with contract terms.

10.4.5 Contracts involving "Funds Held on behalf of the Board" shall be made individually to a specific named fund and shall comply with the requirements of the Charities Acts and regulations.

10.4.6 The Finance Director shall ensure that the arrangements for financial control and the financial and technical audit of building and engineering contracts and property transactions comply with guidance contained within The Property Transaction Handbook CEL (2011)08 and SCIM CEL (2009)19.

10.5 Grants and Similar Payments

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10.5.1 Any grants or similar payments to local authorities and voluntary organisations or other bodies shall comply with procedures laid down by the Finance Director which shall be in accordance with the relevant Acts.

10.5.2 The financial limits for officers' approval of grants or similar payments are set out in the Scheme of Delegation.

10.6 In-house Services

10.6.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering.

10.6.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a) Service specification group, comprising the Chief Executive or nominated officer(s) and specialist(s)
b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support
c) Evaluation group, comprising normally a specialist officer, a procurement officer and a Finance Director representative. For services having a likely annual expenditure exceeding £250,000, a Non-Executive Director should be a member of the evaluation group.

10.6.3 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

10.6.4 The evaluation group shall make recommendations to the Board.

10.6.5 The Chief Executive shall nominate an officer to oversee and manage the contract.

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11 STORES AND RECEIPT OF GOODS

11.1.1 Subject to the responsibility of the Finance Director for the systems of control, overall responsibility for the control of stores shall be delegated to the Procurement Manager by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Finance Director. The control of Pharmaceutical stocks shall be the responsibility of a nominated pharmaceutical officer; the control of fuel oil and bio-fuel of a designated facilities manager.

11.1.2 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the nominated managers.

11.1.3 Wherever practicable, stocks should be marked as health service property.

11.1.4 The Finance Director shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

11.1.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Finance Director.

11.1.6 The nominated managers shall be responsible for a system approved by the Finance Director for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Finance Director any evidence of significant overstocking and of any negligence or malpractice (see also 15, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

11.1.7 Stock levels should be kept to a minimum consistent with operational efficiency.

11.1.8 Stocktaking arrangements shall be agreed with the Finance Director and there shall be a physical check covering all items in store at least once a year.

11.1.9 Those stores designated by the Finance Director as comprising more than seven days of normal use should be:

a) Subjected to annual or continuous stock-take
b) Valued at the lower of cost and net realisable value.

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12 RISK MANAGEMENT AND INSURANCE

12.1.1 The Chief Executive shall ensure that the Board has a programme of risk management which will be approved and monitored by the Board.

12.1.2 The programme of risk management shall include:

a) A process for identifying and quantifying risks and potential liabilities
b) Engendering among all levels of staff a positive attitude towards the identification and control of risk
c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk
d) Contingency plans to offset the impact of adverse events, including a business continuity plan
e) Audit arrangements including; incident reporting and review, internal audit, clinical audit, health and safety review
f) Arrangements to review and update the risk management programme
g) Development of a financial risk management strategy to cope with possible in-year variations to the initially set budgets.

12.1.3 The existence, integration and evaluation of the above elements will provide a basis for the Audit Committee to provide appropriate assurance to the Directors that the necessary controls are in place to allow the Directors to sign the Governance Statement in keeping with Corporate Governance in the NHS.

12.1.4 The Finance Director shall ensure that appropriate insurance arrangements exist in accordance with the risk management programme.

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13 INFORMATION TECHNOLOGY

13.1.1 The Finance Director is responsible for the accuracy and security of the computerised financial data of the Board and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Board's data, programs and computer hardware for which she/ he is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 and General Data Protection Regulations (EU) 2016/679 (GDPR).
b) Ensure that adequate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system
c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment
d) Ensure that the Board is compliant with information regulation and legislation
e) Ensure that electronic signatures are only used with the written approval of the Finance Director
f) Ensure that adequate controls exist for all acquisition/disposal of computer equipment
g) Ensure that an adequate audit trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out
h) Ensure that contingency planning, including business continuity, is undertaken and that adequate contingency arrangements are in place.

13.1.2 The Finance Director shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

13.1.3 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Health Boards /Boards in the area wish to sponsor jointly) all responsible directors and employees will send to the Finance Director:

a) Details of the outline design of the system
b) Contract details and/or standard contract conditions
c) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

These should form part of the national e-Health platform and be procured using framework agreements as set out in section 10.2.2, unless not suitable for the organisations due to cost or functionality.

13.1.4 The Finance Director shall ensure that for contracts for computer services for financial applications with another body, the Board periodically seek assurances that adequate controls are in operation, such as service audits.

13.1.5 Where computer systems have an impact on corporate financial systems the Finance Director shall satisfy him/herself that:

a) Systems acquisition, development and maintenance are in line with corporate policies such as the eHealth Strategy
b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that an audit trail exists
c) Systems are appropriate for future business need as well as the present
d) Finance Directorate staff have access to such data
e) Such computer audit reviews as are considered necessary are being carried out.

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13.1.6 The Associate Medical Director shall devise and implement any necessary procedures to protect the Board and individuals from inappropriate use or misuse of patient confidential information held on computer files after taking account of the Data Protection Act 1998 and General Data Protection Regulations (EU) 2016/679 (GDPR). The appointed Information Governance and Data Security Officer will provide the same assurances over all other non patient data.

13.1.7 The Finance Director shall devise and implement any necessary procedures to comply with the Freedom of Information (Scotland) Act 2002.

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14 AUDIT

14.1 Audit Committee

14.1.1 In accordance with Standing Orders the Board shall formally establish an Audit Committee, with clearly defined terms of reference, which will consider:

a) Internal control and corporate governance, including ensuring that relevant controls are in place and that appropriate assurances can be provided to allow the directors to sign the required statements
b) Internal audit
c) External audit
d) Standing orders and standing financial instructions
e) Accounting policies
f) Annual accounts (including the schedules of losses and compensations).

14.1.2 Where the Audit Committee is satisfied there is evidence of ultra vires transactions, evidence of improper acts, or any other issue, the Chair of the Audit Committee should raise the matter at a meeting of the Board or convene an emergency Board meeting if required. Exceptionally, the matter may need to be referred to the SGHSCD.

14.1.3 It is the responsibility of the Audit Committee with the guidance of the Finance Director to ensure that both an effective and cost effective internal audit service is provided. The Finance Director will retender Internal Audit services at least every five years. The Review panel will include the Chairman of the Audit Committee, the Chief Executive and the Finance Director and may also include other members of the Audit Committee. Tendering will be done on the basis of Technical ability, a Qualitative assessment and affordability.

14.2 Finance Director

14.2.1 The Finance Director is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective internal audit function
b) Ensuring that Internal Audit is adequate and meets the NHS mandatory audit standards
c) With regard to the Governance Statement, arranging for the provision of the necessary compliance evidence which would:

- Identify and disclose where there is a significant control weakness
- Show where a control has been introduced during the financial year;

d) Developing and documenting an effective Fraud, Theft and Other Financial Irregularity Policy, and
e) Investigating cases of fraud, misappropriation or other irregularities, in consultation with the Chief Internal Auditor, Counter Fraud Service and the Police, where appropriate and shall notify the Chief Executive and Audit Committee
f) Ensuring that the Chief Internal Auditor prepares a detailed operational plan each financial year for approval by the Audit Committee
g) Ensuring that an annual internal audit report is prepared by the Chief Internal Auditor, in accordance with the timetable laid down by the Audit Committee, for the consideration of the Audit Committee and the Board. The report must cover:

- A clear statement on the effectiveness of internal control
- Major internal control weaknesses discovered
- Progress on the implementation of internal audit recommendations
- Progress against plan over the previous year.

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14.2.2 The Finance Director or designated auditors are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature
b) Access at all reasonable times to any land, premises or employees of the Board
c) The production of any cash, stores or other property of the Board under an employee's control
d) Explanations concerning any matter under investigation.

14.3 Internal Audit

14.3.1 The role, objectives and scope of Internal Audit are set out in the mandatory Public Sector Internal Audit Standards.

14.3.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with and the financial effect of relevant established policies, plans and procedures
b) The adequacy and application of financial and other related management controls, including internal financial controls
c) The suitability of financial and other related management data
d) The extent to which the Board's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

- Fraud and other offences
- Poor risk assessment
- Waste, extravagance, inefficient administration
- Poor value for money or other causes.

14.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Finance Director must be notified immediately.

14.3.4 The Chief Internal Auditor, or appointed representative, will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairperson and Chief Executive of the Board.

14.3.5 The Chief Internal Auditor shall be accountable to the Finance Director. The reporting and follow-up systems for internal audit shall be agreed between the Finance Director, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standardsl. The reporting and follow-up systems shall be reviewed at least every 3 years.

14.3.6 The Chief Internal Auditor shall issue reports in accordance with the Internal Audit reporting mechanism agreed by the Audit Committee. Failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Chief Internal Auditor shall seek the advice of the Chairperson of the Board.

14.4 External Audit

14.4.1 The external auditor is concerned with providing an independent assurance of the Board's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. Responsibility for securing the audit of the Board rests with Audit Scotland. The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000.

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14.4.2 The external auditor has a general duty to satisfy him/herself that:

a) The Board's accounts have been properly prepared in accordance with directions given under s86(1) of the National Health Service (Scotland) Act 1978
b) Proper accounting practices have been observed in preparation of the accounts
c) The Board has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources
d) The Internal Audit function is adequate.

14.4.3 In addition to these responsibilities, Audit Scotland's Code of Audit Practice requires the appointed auditor to consider:

a) Whether the statement of accounts presents a true and fair view of the financial position of the Board
b) The Board's main financial systems
c) The arrangements in place at the Board for prevention and detection of fraud and corruption
d) Aspects of the performance of particular services and activities
e) The Board's management arrangements to secure economy, efficiency and effectiveness in the use of resources.

14.4.4 The Board's Audit Committee provides a forum through which Non-Executive Directors can secure an independent view of any major activity within the appointed auditor's remit. The Audit Committee has a responsibility to ensure that the Board receives a cost-effective service and that co-operation with senior managers and Internal Audit is appropriate.

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15 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

15.1.1 The Finance Director shall maintain detailed procedures for the disposal of assets (excluding land) including condemnations, and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of an asset, the head of department or authorised deputy will determine and advise the Finance Director of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Finance Director
b) Recorded by the relevant officer, in a form approved by the Finance Director, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Finance Director.
c) The relevant officer shall ensure that any article disposed of, is done so in accordance with appropriate guidance or regulations.
d) The relevant officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Finance Director who will take the appropriate action.

15.1.4 The Security Director will ensure that the Board complies with the Property Transactions Handbook and will ensure that detailed procedures are in place for the disposal of land.

15.2 Losses and Special Payments

15.2.1 The Finance Director must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 Special payments are defined in more detail in the Scottish Public Finance Manual. The main types which may be relevant to the State Hospital are:

- A compensation payment is one made in respect of unfair dismissal in respect of personal injuries, traffic accidents, damage to property etc, suffered by staff or by others.
- Special severance payments are paid to employees beyond and above normal statutory or contractual requirements when leaving employment in public service whether they resign, are dismissed or reach an agreed termination of contract. See the section of the SPFM on Severance, Early Retirement and Redundancy Terms.
- Ex gratia payments are payments made where there is no legal obligation to pay. There must always, however, be good public policy grounds for making such payments. Into this category will fall some out of court settlements, such as cases where the pursuer has no legal case but the Board wants to stop the litigation because it is costly in time and resources. It would not however include cases where the settlement is a negotiated price to settle a potentially higher legal liability. Other examples of ex gratia payments would be payments as compensation for distress or loss arising from a perceived failure of the Board but where there was no legal obligation to pay.

15.2.3 Within limits delegated to it by the SGHSCD (CEL 10 (2010), the Board, following the recommendation of the Audit Committee, shall review the Summary of Losses and Special Payments which shall be prepared by the Finance Director in the form laid down in the Health Board Manual for Accounts, SFR 18.

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	No of Cases	£	Delegated Limit
Theft / Arson / Wilful Damage			
Cash			10,000
Stores/procurement			20,000
Equipment			10,000
Contracts			10,000
Payroll			10,000
Buildings & Fixtures			20,000
Other			10,000
Fraud, Embezzlement & other irregularities (inc. attempted fraud)			
Cash			10,000
Stores/procurement			20,000
Equipment			10,000
Contracts			10,000
Payroll			10,000
Other			10,000
Nugatory & Fruitless Payments			10,000
Claims Abandoned:			
(a) Private Accommodation			10,000
(b) Road Traffic Acts			20,000
(c) Other			10,000
Stores Losses:			
Incidents of the Service			
- Fire			20,000
- Flood			20,000
- Accident			20,000
Deterioration in Store			20,000
Stocktaking Discrepancies			20,000
Other Causes			20,000
Losses of Furniture & Equipment and Bedding & Linen in circulation:			
Incidents of the Service – Fire			10,000
- Flood			10,000
- Accident			10,000
Disclosed at physical check			10,000
Other Causes			10,000
Compensation Payments - legal obligation			
Clinical			250,000
Non-clinical			100,000
Ex-gratia payments:			
Extra-contractual Payments			10,000
Compensation Payments - ex-gratia - Clinical			250,000
Compensation Payments - ex-gratia - Non Clinical			100,000
Compensation Payments - ex-gratia - Financial Loss			25,000
Other Payments			2,500
Damage to Buildings and Fixtures:			
Incidents of the Service – Fire			
- Fire			20,000
- Flood			20,000
- Accident			20,000
- Other Causes			20,000
Extra-Statutory & Extra-regulationary Payments			0
Gifts in cash or kind			10,000
Other Losses			10,000

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15.2.4 The Finance Director shall be authorised to take any necessary steps to safeguard the Board's interests in bankruptcies and company liquidations.

15.2.5 For any loss, the Finance Director should consider whether any insurance claim can be made.

15.2.6 The Board shall delegate to the Chief Executive and the Finance Director, acting jointly, its responsibility for the approval of losses and authorisation of special payments for such categories or values of losses as within limits to the Board by the SGHSCD.

15.2.7 The Finance Director shall maintain a Losses and Special Payments Register in which write-off action is recorded – which shall be reviewed on an annual basis.

15.2.8 No losses or special payments exceeding delegated limits (CEL 10 (2010)) shall be written off or made without the prior approval of the SGHSCD.

15.3 Theft, Fraud, Embezzlement, Corruption and Other Financial Irregularities

15.3.1 The Finance Director must prepare a 'fraud response plan', incorporating the requirements of HDL (2004) 23, updated by CEL(2009)18, that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

15.3.2 The Finance Director will be the nominated contact for the National Fraud Initiative (NFI) and will authorise the release of the required data for this purpose. The Finance Director may delegate the NFI investigation and reporting requirements, to suitable representatives. The Finance Director will ensure that all staff receive the required notifications that their information will be used for this purpose.

15.3.3 The following procedures should be followed, as a minimum, in cases of suspected theft, fraud, embezzlement, corruption or other financial irregularities to comply with Scottish Government Health Department Circular No HDL(2002)88 This procedure also applies to any non-public funds.

15.3.4 The Chief Executive has the responsibility to designate an officer within the Board with specific responsibility for co-ordinating action where there are reasonable grounds for believing that an item of property, including cash, has been stolen.

15.3.5 It is the designated officer's responsibility to inform as he/she deems appropriate the police, the Counter Fraud Services (CFS), the appropriate director, the Appointed Auditor and Internal Auditor where such an occurrence is suspected.

15.3.6 Where any officer of the Board has grounds to suspect that any of the above activities has occurred, his or her local manager should be notified without delay. Local managers should in turn immediately notify the Board's Finance Director, who should ensure consultation with the CFS, normally by the Fraud Liaison Officer. It is essential that preliminary enquiries are carried out in strict confidence and with as much speed as possible.

15.3.7 If, in exceptional circumstances, the Finance Director and the Fraud Liaison Officer are unavailable the local manager will report the circumstances to the Chief Executive who will be responsible for informing the CFS. As soon as possible thereafter the Director of Finance should be advised of the situation.

15.3.8 Where preliminary investigations suggest that prima facie grounds exist for believing that a criminal offence has been committed, the CFS will undertake the investigation, on behalf of, and in co-operation with, the Board. At all stages the Finance Director and the Fraud Liaison Officer will be kept informed of developments on such cases. All referrals to the CFS must also be copied to the Appointed Auditor.

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15.3.9 The Chief Executive has also the responsibility to designate an officer within the Board as Counter Fraud Champion. The role is a strategic one, and focuses on spearheading change in culture and attitudes towards NHS fraud. Full background to this role is included within CEL 3 (2008). As such the role of Champion will complement the role of the Fraud Liaison Officer and includes responsibility for:

- Raising the profile of counter fraud initiatives and publicity
- Ensuring recommendations from investigation reports by NHSScotland Counter Fraud Services (CFS) are implemented
- Monitor implementation of CFS recommendations and ensure compliance with them
- Set clear guidelines and measures for monitoring the effectiveness of implementation.

15.4 Remedial action

15.4.1 As with all categories of loss, once the circumstances of a case are known the Finance Director will require to take immediate steps to ensure that so far as possible these do not recur. However, no such action will be taken if it would prove prejudicial to the effective prosecution of the case. It will be necessary to identify any defects in the control systems, which may have enabled the initial loss to occur, and to decide on any measures to prevent recurrence.

15.5 Reporting to the SGHSCD

15.5.1 Under Enhanced Reporting of NHS Fraud & Attempted Fraud CEL (2010)10 an annual return SFR18 must be completed, as part of the annual account process, to report all cases of Fraud to the SGHSCD. There may be occasions where the nature of scale of the alleged offence or the position of the person or persons involved, could give rise to national or local controversy and publicity. Moreover, there may be cases where the alleged fraud appears to have been of a particularly ingenious nature or where it concerns an organisation with which other health sector bodies may also have dealings. In all such cases, the SGHSCD must be notified of the main circumstance of the case at the same time as an approach is made to the CFS. However all significant or unusual incidents involving patients' finds or endowments should be reported to the SGHSCD.

15.6 Responses to Press Enquiries

15.6.1 Where the publicity surrounding a particular case of alleged financial irregularity attracts enquiries from the press or other media, the Chief Executive should ensure that the relevant officials are fully aware of the importance of avoiding issuing any statements, which may be regarded as prejudicial to the outcome of criminal proceedings.

15.7 Counter Fraud Services (CFS) – Access to Data

15.7.1 CFS work closely with the Board and may at times require access to evidence relating to ongoing investigations. Scottish Government Health & Social Care Directorate endorse that Boards should support the important role played by CFS and that any CFS staff acting on the Finance Director's behalf should be allowed access to the following:

- All records, documents and correspondence relating to relevant transactions
- At all reasonable times, access to any premises or land of The State Hospital
- The production or identification by any employee of the Board, cash, stores or other property under the employee's control

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16 PATIENTS' PROPERTY

16.1.1 The Board has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients.

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Board will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.1.3 The Security Director must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.1.4 Where SGHSCD instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Finance Director.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained. Any payment by the Hospital towards funeral expenses should be approved by the Finance Director.

16.1.6 Staff should be informed, on appointment, formally in writing by the Human Resources Director and by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

16.1.8 The Finance Director shall prepare an abstract of receipts and payments of patients' private funds in the form laid down in the Health Board Accounts Manual. This abstract shall be audited independently and presented to the Audit Committee annually.

16.1.9 In general staff are not allowed to receive benefit from any patient's Will. If staff become aware of an intention to include themselves in a Will, staff should discourage such action. This should be reported to the appropriate manager. Anyone receiving a bequest should report this to their line manager to determine further action. Except in cases of the direst emergency, staff should not be involved in witnessing or otherwise in the making of a patient's Will. Any reference of such matters by a patient to a member of staff should immediately be communicated to Advocacy or the Board management, who may arrange for a local solicitor's services to be made available to the patient, if that is wished.

16.1.10 In order to comply with the Gambling Act 2005, patients are not allowed to gamble or place bets. Clinical staff should therefore not approve any requests from patients to withdraw funds for this purpose.

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17 RETENTION OF DOCUMENTS

17.1.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in SHM 58/60, NHS MEL (1993)152 “Guidance for the Retention and Destruction of Health Records” and HDL (2006) 28 “The Management, Retention and Disposal of Administrative Records”, The Scottish Government records management: NHS code of practice (Scotland) version 2.1: 11 January 2012.

17.1.2 The documents held in archives shall be capable of retrieval by authorised persons.

17.1.3 Documents held under the above guidance shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

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18 STANDARDS OF BUSINESS CONDUCT

18.1 General Responsibility

18.1.1 It shall be the responsibility of the Chief Executive to:

- Ensure that the Scottish Government Health and Social Care Directorate guidelines on standards of business conduct for NHS staff (MEL (1994) 48) are brought to the attention of all staff, and effectively implemented
- Develop local policies and the processes to implement them, in consultation with staff and local staff representatives
- Ensure that such policies are kept up to date.

18.1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000 provides a code of conduct for members of The State Hospitals Board for Scotland. This code was incorporated into Board Standing Orders in May 2003. The principles that apply to gifts and hospitality set out in Standing Orders (Section 3) apply equally to all staff.

18.2 Acceptance of Gifts and Hospitality

18.2.1 The acceptance of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Corruption Acts 1906 and 1916. In the event of a contractor or other supplier of goods or services making such an offer to any officer, either for their personal benefit or the "benefit" of the Board, the guidance given in HSG(93)5 and NHS Circular HDL (2003) 62 (or subsequent guidance issued by the Scottish Government Health and Social Care Department) must be followed. Initially, the matter must be reported to an individual's line manager, or the relevant Director. Acceptance, or refusal, of gifts or hospitality must be entered in a Register of Hospitality and Interests, which will be maintained by the Finance Director. The register will also record details of hospitality provided by the Board's employees:

a) Articles of a low intrinsic value, such as business diaries or calendars, need not be refused
b) Care should also be taken in accepting hospitality such as lunches and dinners, corporate hospitality events etc. All such offers should be reported to the officers line manager before accepting.
c) Visits at suppliers expense to inspect equipment etc should not be undertaken without the prior approval of the Chief Executive and in the case of the Chief Executive by the prior approval of the Chairman. Costs associated with such visits will be borne by The State Hospital.
d) If officers are involved in the acquisition of goods and services they should adhere to the ethical code of the Institute of Purchasing and Supply.
e) Officers should ensure that the acceptance of commercial sponsorship will not influence or jeopardise purchasing decisions.

18.3 Private Transactions

18.3.1 Where offers of goods or services do not involve inducement or reward, employees should still not accept gifts from commercial sources other than inexpensive articles such as calendars or diaries. If any such gifts should arrive unsolicited, the advice of the Finance Director should be sought.

18.4 Declaration of Interest

18.4.1 Employees having official dealings with contractors and other suppliers of goods or services should avoid transacting any kind of private business with them by means other than normal commercial channels. No favour or preference as regards price or otherwise which is not generally available should be sought or accepted.

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18.4.2 In accordance with Standing Order 5, the Chief Executive shall be advised of declared pecuniary interests of Directors or senior staff for recording in the Register of Hospitality and Interests.

18.4.3 The Finance Director is responsible for putting in place arrangements for staff to declare interests. In accordance with Data Protection principles, access is strictly controlled on a need to know basis. The only department likely to be passed this information would be the Procurement Department where there may be concern about the possibility of entering into contracts with organisations which could conflict with registered interests.

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Annex 1 Minimum Financial Controls
(extract from guidance on preparation of Statement of Internal Control March 2010)

Corporate Governance	
The Control Environment	
Public Finance & Accountability (Scotland) Act 2000 HDL(2003)11	Code of Corporate Governance
SSI(2001)301/2 MEL(1994)80	Standing Orders
MEL(1994)80, Annex 4 MEL(1992)35	Scheme of Reservation and Delegation
Appointed Officer Memorandum SSI(2001) 301/2	Accountable Officer Responsibilities
MEL(1994)80, MEL(1996)42 HDL(2002)25, SGHD Audit Committee Handbook	Audit Committee
HDL(2002)11, MEL(1996)42	Internal Audit function
Section 2 of the National Health Service Reform (Scotland) Act 2004 HDL(2002)11	Structures of assurance including CHPS
The Community Care (Joint Working etc.) (Scotland) Regulations 2002 CCD5/2005 CCD11/2002 Governance for Joint Services (Paper by Audit Scotland, Scottish Government & COSLA)	Partnerships including Joint Futures
Identification and Evaluation of Risks and Objectives	
HDL(2006)12 HDL(2004)46	Local Development Plan and regional planning
MEL(1994)15, MEL(1999)14, MEL(1994)80	Risk Management
Control Processes	
	Compliance with laws and regulations

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Monitoring and Corrective Action	
MEL(1994)80, Annex 5	Performance reporting
MEL(1994)80, Annex 9	Policies, procedures and control frameworks
Best Value in Public Services – Secondary Guidance to Accountable Officers	Best Value
Clinical Governance	
MEL(1998)75, MEL(1998)29, MEL(2000)29, HDL(2005)41	Clinical Governance Committee
HIS Standards	Health Improvement Scotland Reports
Staff Governance	
HDL(2004)39, HDL(2005)52 Staff Governance Standard	Staff Governance Committee
HDL(2006)54, HDL(2006)23 HDL(2002)64, MEL(1994)80, Annex 1	Remuneration Committee
KSF/Agenda for Change guidance	Performance management and development
Financial Governance	
SI(1994)No. 468	Financial reporting
MEL(1994)80 NHS 1974(GEN)88	Standing Financial Instructions
MEL(1994)48 Standards Commission	Standards of Business Conduct Model Code of Conduct
HDL(2005)5 MEL(1994)48 RIPSA CEL11(2013)	Fraud Theft & Corruption Policy and Response Plan
NHS 1974(GEN)88	Budgetary control system
SI(94) No 468, MEL(1994)80, Annex 9 HDL(2001)49	Financial Procedures

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MEL(1992)35 &59 ,MEL(1998)9	Acquisition, use, disposal and safeguarding of assets
MEL(1992)18 HDL(2002)87, MEL(1996)48, SCIM	Capital investment control and project management
MEL(1992)8 MEL(1992)9	Property transactions procedures Delegation of authority: land transactions
Annual Accounts Manual Capital Accounting Manual SPFM	Financial accounting and annual accounts presentation Capital accounting policy and guidance Financial policies and guidance for Scottish central government bodies
Schedule 6, part 11,section 6(1) 1990 Health Act Accountable Officer Memorandum	Arrangements to ensure resources are used effectively, efficiently and economically
Scottish Government IFRS Technical Application Notes	Application of International Financial Reporting Standards from 2009/10 and the International Financial Reporting Manual issued by HM Treasury
Health Workforce & Performance Directorate Guidance 13 March 2015	Settlement Agreements
Information Governance	
MEL(1994)64 HDL(2005)46 NHSScotland eHealth Strategy Board guidance	IM&T strategy
HDL(2006)41 MEL(1992)14 MEL(1992)45 NHS Information System Security Manual issued under MEL(1994)75	Information Security Policy
NHS Scotland Information Governance Standards	Information Governance Toolkit and annual improvement plan

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THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 April 2023
Agenda Reference:	Item No: 16
Sponsoring Director:	Chair
Author(s):	Head of Corporate Governance/Board Secretary
Title of Report:	Annual Review of Standing Orders and Code of Conduct
Purpose of Report:	For Decision

1 SITUATION

On 6 April 2023, the Audit and Risk Committee reviewed the Board's Standing Orders as well as Members Code of Conduct as part of the annual review of standing documentation.

2 BACKGROUND

The Audit and Risk Committee is required conduct this review of standing documentation, and to make its recommendations to the Board on this basis.

3 ASSESSMENT

The Board Standing Orders were fully updated in 2020 in line with NHS national guidance and prescribed formatting, and review has not highlighted any areas that require change. There are no further amendments proposed at a national level.

The Members Code of Conduct are based on the principles of Section 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, and there are no proposed changes to the code.

On this basis the Audit and Risk Committee approved each for onward submission to the Board.

Copies of each are appendixed to this report.

4 RECOMMENDATION

The Board is asked to approve the review of the Standing Orders and Members Code of Conduct and to confirm that no amendments are required.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Ensures that the Board's standing orders and members code of conduct are up to date in respect of regulatory guidance and
Workforce Implications	None identified
Financial Implications	None identified
Route to the Board Which groups were involved in contributing to the paper and recommendations?	Required as part of annual review of standing documentation. Audit and Risk Committee reviewed and approved and for onward recommendation to the Board.
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ **There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

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

1 General

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

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

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

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

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

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

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

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

Board Members – Ethical Conduct

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

the Register, he or she must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

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

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

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

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

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

2 Chair

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

3 Vice-Chair

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

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

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

4 Calling and Notice of Board Meetings

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

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

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

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

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

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

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

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

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

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

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

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

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

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

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

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

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

Quorum

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

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

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

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

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

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

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

Adjournment

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

Business of the Meeting

The Agenda

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

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

Decision-Making

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

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

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

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

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

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

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

Board Meeting in Private Session

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

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

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

<u>Minutes</u>

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.

A MEMBERS' CODE OF CONDUCT

1 Introduction

The Scottish public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties for The State Hospitals Board for Scotland. You must meet those expectations by ensuring that your conduct is above reproach.

The Ethical Standards in Public Life etc. (Scotland) Act 2000 provides for new Codes of Conduct for local authority councillors and members of relevant public bodies; imposes on councils and relevant public bodies a duty to help their members to comply with the relevant code; and establishes a Standards Commission for Scotland to oversee the new framework and deal with alleged breaches of the codes.

This Code covers members of The State Hospitals Board for Scotland. As a member of the State Hospitals Board for Scotland, it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct.

Guidance on the Code of Conduct

You must observe the rules of conduct contained in this Code. It is your personal responsibility to comply with these and review regularly, and at least annually, your personal circumstances with this in mind, particularly when your circumstances change. You must not at any time advocate or encourage any action contrary to the Code of Conduct.

The Code has been developed in line with the key principles listed in section 2 and provides additional information on how the principles should be interpreted and applied in practice. No Code can provide for all circumstances and if you are uncertain about how the rules apply, you should seek advice from the Chairperson, or the Chief Executive. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

Enforcement

Section 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 sets out the provisions for dealing with alleged breaches of this Code of Conduct and the sanctions that shall be applied if the Standards Commission finds that there has been a breach of the Code. Those sanctions are outlined in Annex A.

2 Key Principles of the Code of Conduct

The general principles upon which this Model Code of Conduct are based are:

Public Service

You have a duty to act in accordance with the core tasks and in the interests of the State Hospitals Board for Scotland of which you are a member.

Selflessness

You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

Integrity

You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

Objectivity

You must make decisions solely on merit when carrying out public business.

Accountability and Stewardship

You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that the State Hospital uses its resources prudently and in accordance with the law.

Openness

You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands, or in the interests of patient confidentiality.

Honesty

You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

You have a duty to promote and support these principles by leadership and example, to maintain and strengthen the public's trust and confidence in the integrity of the State Hospitals Board for Scotland and its members in conducting public business.

Respect

You must respect fellow members and employees of the State Hospital and the role they play, treating them with courtesy at all times.

You should apply the principles of this Code to your dealings with fellow members of the State Hospitals Board for Scotland and its employees.

3 General Conduct

Relationships with Employees of the State Hospital

You will treat any staff employed by the State Hospital with courtesy and respect. It is expected that employees will show you the same consideration in return.

Allowances

You must comply with any rules of the State Hospital regarding remuneration, allowances and expenses.

Gifts and Hospitality

You must never canvass or seek gifts or hospitality.

You are responsible for your decisions connected with the offer or acceptance of gifts or hospitality and for avoiding the risk of damage to public confidence in the State Hospitals Board for Scotland. As a general guide, it is usually appropriate to refuse offers except:

(a) isolated gifts of a trivial character or inexpensive seasonal gifts such as a calendar or diary, or other simple items of office equipment of modest value;

(b) normal hospitality associated with your duties and which would reasonably be regarded as inappropriate to refuse; or

(c) gifts received on behalf of the State Hospitals Board for Scotland.

You must not accept any offer by way of gift or hospitality which could give rise to a reasonable suspicion of influence on your part to show favour, or disadvantage, to any individual or organisation. You should also consider whether there may be any reasonable perception that any gift received by your spouse or co-habitee or by any company in which you have a controlling interest, or by a partnership of which you are a partner, can or would influence your judgement. The term “gift” includes benefits such as relief from indebtedness, loan concessions, or provision of services at a cost below that generally charged to members of the public.

You must not accept repeated hospitality from the same source. You must record details of any gifts and hospitality received and the record must be made available for public inspection.

You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision made by the State Hospitals Board for Scotland may be involved in determining, or who is seeking to do business with your organisation, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit to inspect equipment, vehicles, land or property, then as a general rule you should ensure that the State Hospitals Board for Scotland pays for the costs of these visits.

Confidentiality Requirements

There may be times when you will be required to treat discussions, documents or other information relating to the work of the State Hospitals Board for Scotland in a confidential manner. You will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. There are provisions in legislation on the categories of confidential and exempt information and you must always respect and comply with the requirement to keep such information private.

It is unacceptable to disclose any information to which you have privileged access, for example derived from a confidential document, either orally or in writing. In the case of other documents and information, you are requested to exercise your judgement as to what should or should not be made available to outside bodies or individuals. In any event, such information should never be used for the purpose of personal or financial gain, or used in such a way as to bring the State Hospitals Board for Scotland into disrepute.

Use of Public Body Facilities

Members of the State Hospitals Board for Scotland must not misuse facilities, equipment, stationery, telephony and services, or use them for party political or campaigning activities. Use of such equipment and services, etc must be in accordance with the State Hospitals Board for Scotland policy and rules on their usage.

Appointment to Partner Organisations

You may be appointed, or nominated by the State Hospitals Board for Scotland, as a member of another body or organisation. If so, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body. No NHS body is permitted to nominate a person to be a director of another Company.

4 Registration of Interests

The following paragraphs set out the kinds of interests, financial and otherwise which you have to register. These are called "Registerable Interests". You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in the State Hospitals Board for Scotland Register.

The Board will maintain a formal Register of Members' Interest, which should be available to the public, on request from Corporate Services, at the State Hospital, Carstairs. The Register will include details of all directorships and other relevant and material interests which have been declared by the Chairperson, executive and non-executive Board Directors/Members.

This Code sets out the categories of interests, which you must register. Annex B contains key definitions to help you decide what is required when registering your interests under any particular category. These categories are listed below with explanatory notes designed to help you decide what is required when registering your interests under any particular category.

Category One: Remuneration

You have a Registerable Interest where you receive remuneration by virtue of being:

- employed;
- self-employed;
- the holder of an office;
- a director of an undertaking;
- a partner in a firm; or
- undertaking a trade, profession or vocation or any other work.

The amount of remuneration does not require to be registered and remuneration received as a Member does not have to be registered.

If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two, "Related Undertakings".

If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

When registering employment, you must give the name of the employer, the nature of its business, and the nature of the post held in the organisation.

When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a partnership, you must give the name of the partnership and the nature of its business.

Where you undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if you write for a newspaper, you must give the name of the publication, and the frequency of articles for which you are paid.

When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and the nature of its business.

Registration of a pension is not required as this falls outside the scope of the category.

Category Two: Related Undertakings

You must register any directorships held which are themselves not remunerated but where the company (or other undertaking) in question is a subsidiary of, or a parent of, a company (or other undertaking) in which you hold a remunerated directorship.

You must register the name of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

The situations to which the above paragraphs apply are as follows:

- you are a director of a board of an undertaking and receive remuneration – declared under category one – and
- you are a director of a parent or subsidiary undertaking but do not receive remuneration in that capacity.

Category Three: Contracts

You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in category 5 below) have made a contract with the State Hospitals Board for Scotland of which you are a member:

(i) under which goods or services are to be provided, or works are to be executed;

and

(ii) which has not been fully discharged.

You must register a description of the contract, including its duration, but excluding the consideration.

Category Four: Houses, Land and Buildings

You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the State Hospitals Board for Scotland.

The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making. If in doubt, you may consult with the Standards Commission.

Category Five: Shares and Securities

You have a registerable interest where you have an interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of the State Hospitals Board for Scotland. You are not required to register the value of such interests.

The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in shares and securities could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making. If in doubt, you may consult with the Standards Commission.

Category Six: Non–Financial Interests

You may also have a registerable interest if you have non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the State Hospitals Board for Scotland. It is important that relevant interests such as membership or holding office in other public bodies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described.

The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any non-financial interest could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making. If in doubt, you may consult with the Standards Commission.

5 Declaration of Interests

Introduction

The key principles of the Code, especially those in relation to integrity, honesty and openness, are given further practical effect by the requirement for you to declare certain interests in proceedings of the State Hospitals Board for Scotland. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions.

Public bodies inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in the State Hospitals Board for Scotland and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.

In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must keep in mind that the test is whether a member of the public, acting reasonably, might think that a particular interest could influence you.

If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be

perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration and you are advised to err on the side of caution. You may also seek advice from the Standards Commission.

At the time Board Members' interests are declared, they should be recorded in the Board minutes. The minutes containing information about the interests of Board Members should be drawn to the attention of the Board's internal and external auditors. Any changes should also be declared within 4 weeks of the change occurring and recorded in the Board minutes.

Any remuneration, compensation or allowances payable to a Chairperson or other non-executive Member by virtue of paragraph 4 of Part I, or paragraph 13 of Part II, of Schedule I of the National Health Service (Scotland) Act of 1978 or any amendment thereof, shall not be treated as a pecuniary interest for the purpose of these Standing Orders.

Interests which Require Declaration

Interests which require to be declared may be financial or non-financial. They may or may not be interests which are registerable under this Code. Most of the interests to be declared will be your personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration.

Shares and Securities

Any financial interest which is registerable must be declared. You may have to declare interests in shares and securities, over and above those registerable under category five of section 4 of this Code. You may, for example, in the course of employment or self-employment, be engaged in providing professional advice to a person whose interests are a component of a matter to be dealt with by a Board.

You have a declarable interest where an interest becomes of direct relevance to a matter before the body on which you serve and you have shares comprised in the share capital of a company or other body and the nominal value of the shares is:

(i) greater than 1% of the issued share capital of the company or other body; or

(ii) greater than £25,000.

You are required to declare the name of the company only, not the size or nature of the holding.

Houses, Land and Buildings

Any interest in houses, land and buildings which is registerable under category four of section 4 of this Code must be declared, as well as any similar interests which arise as a result of specific discussions or operations of the State Hospitals Board for Scotland.

Non-Financial Interests

If you have a registered non-financial interest under category six of section 4 of this Code you have recognised that it is significant. There is therefore a very strong presumption that this interest will be declared where there is any link between a matter which requires your attention as a member of the State Hospitals Board for Scotland and the registered interest. Non-financial interests include membership or holding office in other public bodies, clubs, societies, trade unions and organisations including voluntary organisations. They become declarable if and when members of the public might reasonably think they could influence your actions, speeches or votes in the decisions of the State Hospitals Board for Scotland.

You may serve on other bodies as a result of express nomination or appointment by the State Hospitals Board for Scotland or otherwise by virtue of being a member of the State Hospitals Board for Scotland. You must always remember the public interest points towards transparency particularly where there is a possible divergence of interest between different public authorities.

You will also have other private and personal interests and may serve, or be associated with, bodies, societies and organisations as a result of your private and personal interests and not because of your role as a member of the State Hospitals Board for Scotland. In the context of any particular matter you will have to decide whether to declare a non-financial interest. You should declare an interest unless you believe that, in the particular circumstances, the interest is irrelevant or without significance. In reaching a view you should consider whether the interest (whether taking the form of association or the holding of office) would be seen by a member of the public acting reasonably in a different light because it is the interest of a person who is a member as opposed to the interest of an ordinary member of the public.

Interests of Other Persons

The Code requires only your interests to be registered. You may, however, have to consider whether you should declare an interest in regard to the financial interests of your spouse or cohabitee which are known to you. You may have to give similar consideration to any known non-financial interest of a spouse or cohabitee. You have to ask yourself whether a member of the public acting reasonably would regard these interests as effectively the same as your interests in the sense of potential effect on your responsibilities as a member of the State Hospitals Board for Scotland.

The interests known to you, both financial and non-financial, of relatives and close friends may have to be declared. This Code does not attempt the task of defining “relative” or “friend”. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of the State Hospitals Board for Scotland.

Making a Declaration

You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether agendas for meetings raise any issue of declaration of interest. Your declaration of interest must be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed you must declare the interest as soon as you realise it is necessary.

The oral statement of declaration of interest should identify the item or items of business to which it relates. The statement should begin with the words "I declare an interest". The statement must be sufficiently informative to enable those at the meeting to understand the nature of your interest but need not give a detailed description of the interest.

A "Declaration of Interests Form" is required to be completed on an annual basis.

Effect of Declaration

Declaring a financial interest has the effect of prohibiting any participation in discussion and voting. A declaration of a non-financial interest involves a further exercise of judgement on your part. You must consider the relationship between the interests which have been declared and the particular matter to be considered and relevant individual circumstances surrounding the particular matter.

In the final analysis the conclusive test is whether, in the particular circumstances of the item of business, and knowing all the relevant facts, a member of the public acting reasonably would consider that you might be influenced by the interest in your role as a member of the State Hospitals Board for Scotland and that it would therefore be wrong to take part in any discussion or decision-making. If you, in conscience, believe that your continued presence would not fall foul of this objective test, then declaring an interest will not preclude your involvement in discussion or voting. If you are not confident about the application of this objective yardstick, you must play no part in discussion and must leave the meeting room until discussion of the particular item is concluded.

Dispensations

In very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and non-financial interests which would otherwise prohibit you from taking part and voting on matters coming before your public body and its committees. Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

6 Lobbying and Access to Members of Public Bodies

In order for the State Hospitals Board for Scotland to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which the State Hospitals Board for Scotland conducts its business.

You will need to be able to consider evidence and arguments advanced by a wide range of organisations and individuals in order to perform your duties effectively. Some of these organisations and individuals will make their views known directly to individual members. The rules in this Code set out how you should conduct yourself in your contacts with those who would seek to influence you. They are designed to encourage proper interaction between members of public bodies, those they represent and interest groups.

Rules and Guidance

You must not, in relation to contact with any person or organisation who lobbies, do anything which contravenes this Code of Conduct or any other relevant rule of the State Hospitals Board for Scotland or any statutory provision.

You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon the State Hospitals Board for Scotland.

The public must be assured that no person or organisation will gain better access to, or treatment by, you as a result of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a fee basis on behalf of clients be given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of the State Hospitals Board for Scotland.

Before taking any action as a result of being lobbied, you should seek to satisfy yourself about the identity of the person or organisation who is lobbying and the motive for lobbying. You may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that you know the basis on which you are being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code.

You should not accept any paid work

(a) which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation.

(b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence the State Hospitals Board for Scotland and its members. This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the State Hospitals Board for Scotland, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of the State Hospitals Board for Scotland.

The Members Model Code should be read in conjunction with Standing Financial Instructions of the State Hospitals Board for Scotland.

7 Training and Development of Members

The Chairperson of the Board is responsible for ensuring that all executive and non-executive Members make a full contribution to the Board's affairs and must, in consequence, determine the training and development needs of Members and ensure that any gaps in knowledge or experience are resolved.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 April 2023
Agenda Reference:	17
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 28 February 2023
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

2.1 TSH

SG were ordinarily provided with an Annual Operating Plan (OP) and 3-year financial forecast template. The Operating Plan was paused due to Covid and replaced with the Board Remobilisation Plan (BRP); however, we have now once again resumed submission of an Annual Operating Plan for 2022/23.

There are a number of processes that were put in place with individual budget-holders so that the pressures of any remaining Covid-related costs which have continued to be incurred will to be met within the specific directorates as we have continued to return to “business as usual” through 2022/23.

There are delays (attributable to Covid) in the Perimeter Project which are being monitored by the Project Board and for which any delay costs will be reviewed and quantified for consideration for the 2022/23 year-end and into 2023/24, for which we continue to notify SG regarding progress.

The draft base budgets (pending notification of settlement of the final and fully confirmed AFC Pay Circular for 2022/23) currently forecast a breakeven year-end position, set on achieving £0.811m efficiency savings, as referred to in the table in section 4.

This is subject to change once we receive pending confirmation of SG coverage of final pay circulars but to manage this prudently we are also maintaining an element of contingent reserve until the final pay award levels and reimbursement are known from SG – due imminently (see 3.1 note).

2.2 SG Communication

On 14 July 2022, the NHS Scotland Chief Operating Officer and Director of Finance wrote to all Chief Executives and Directors of Finance highlighting Service Priorities and the "considerable financial challenge" for 2022/23, 2023/24 and beyond. Priorities for 2022/23 were noted as:

- Planned care – reduction in waiting times
- Cancer care – enhanced diagnosis and treatment
- Unscheduled care – taking forward the new "Urgent and Unscheduled Care Collaborative" – funding to be confirmed
- Extended flu and Covid vaccinations
- Reduced drug deaths

The letter referred to the 2022/23 Agenda for Change pay offer, with Boards to assume that funding will be provided based on the additional costs associated, and allocations to be confirmed following conclusion of pay negotiations.

It was also noted that Boards are to focus on reducing remaining Covid costs, with the anticipation of no further COVID consequentially in 2022-23 or in future years and any recurring costs to be met through confirmed recurring allocations where now in place (e.g. sustainable vaccination workforce) or from existing baseline budgets. (Funding is expected towards the Test and Protect programme).

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £42.915m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and anticipated additional allocations, the AFC arrears payments and increase have been anticipated for February – a further adjustment will be made March – the allocation letter was not received in time for our M11 reporting period ledger close. RRL is anticipated to cover the shortfall of the original 2% and the average 7.5%.

The Board is reporting an underspend of £0.015m to February 2023; with revenue forecast trajectory variance set at £0.200m underspend (per monitoring template for 'SG').

The March year-end position is also currently anticipated to show a small underspend per draft workings underway, in the process of being finalised with the annual input from our partnership working with NSS for year-end audit.

PAIAW ("Payment as if at work") funding continues to be held as a reserve for the current year. This continues to be a significant element for the Board regarding our high levels of overtime and high nursing vacancies. There is a small pressure for some who have been identified as having potentially been paid incorrectly for which review is underway and which should be resolved soon.

Some pressure potentially remains re prior years' PAIAW still outstanding – claimants now being in the hand of CLO (some of whom have recently been paid.) This was accrued at March 2022 and if required will again be accrued for year-end.

Additional, at March 2022, some costs of the project works started in 2021/22 re the eRostering project *(see para 3.2)*, M365 licences, and related pressures were accrued to fund an element of anticipated costs in 2022/23, which have now been realised.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -

Covid-19
See notes above. Some new posts will be reviewed for permanency, and a schedule of such posts is being collated for SG review, further to discussion with SG, Chief Executive and Finance and eHealth Director.

eRostering Project
While provision has been noted for the contractual implementation costs of the eRostering project in 2022/23, this project is now being rescheduled nationally by NSS to implement across 2023/24 and 2024/25. Additionally, currently unfunded are the additional posts expected to be required in order to manage this implementation – being three posts requiring an annual funding of approx. £150k. This pressure has been highlighted to SG, and as it is an issue shared by a number of Boards this has been raised by TSH at both DoF and Chief Exec levels as the project is receiving national attention re confirmation of amended timeframes.

Clinical Model review update
There is risk noted that the updated Clinical Model review's financial position is expected to differ in structure from that which was originally considered and evaluated pre-Covid – current indications being that while this is not expected to give additional costs above current levels, originally anticipated savings will not be realised.

Extra PH for Platinum Jubilee
It is noted that there is the cost of one day's additional holiday in 2022/23 (which will recur in 2023/24 for the Coronation holiday).

Benefits
Travel underspend has continued through the year and ongoing budgets will be amended accordingly to reflect changed ways of working. There are also some divisional training underspends noted in-year.

3.3 2023/24 Draft Budget

The 2023/24 draft budget template required by SG has been submitted, noting forecast pressures for the revenue outturn, within which there is a savings requirement of £1.3m.

This increase from 2022/23's savings of £0.8m is due principally to cost pressures specifically highlighted of £600k re energy costs anticipated in the coming year due to market price increases, and £180k noted re taking forward of new posts and structures established through Covid.

While the capital budget for 2023/24 remains at a recurring level of £269k, capital priorities are monitored and agreed through the Capital Group, and priorities for spend in the coming year have been notified to CMT – also noting that additional project funding will be considered when appropriate for any priority projects not affordable through the recurring funding.

3.4 Year-to-date position – allocated by Board Function / Directorate

Directorates	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	Variance (budget less actuals) for period	Budget WTE	Actual WTE
Nursing And Ahp's	24,001	22,167	22,098	69	402.10	411.83
Security And Facilities	6,241	5,758	5,726	32	121.62	114.09
Utilities (extracted from above)	707	648	830	(182)	0.00	0.00
Medical	3,078	2,817	2,670	147	20.55	13.55
Chief Exec	2,087	1,916	1,904	11	22.96	23.14
Human Resources Directorate	1,028	945	902	43	15.15	14.25
Finance	2,876	2,645	2,617	28	29.43	32.45
Cap Charges	2,641	2,421	2,410	10	0.00	0.00
Misc Income	(600)	(550)	(531)	(19)	0.00	0.00
Central Reserves	857	74	199	(124)	0.00	0.00
	42,915	**38,840**	**38,825**	**15**	**611.81**	**609.31**

Nursing – Includes Ward Nursing overtime pressure, and benefit from leavers being replaced by new starts in year, which will contribute to the savings – and offset with vacancies in other departments that gives a net underspend position.

Security & Facilities – Previously highlighted biomass and electricity overspends are noted, with a focus forward on monitoring energy costs in a pressured market. **Utilities** has been extracted from Security to show on its own in order not to distract the Security budget from core activity. There are remaining covid pressures for disposable items being used for patient food delivery (budget was released in January to support this), and food price increases are causing pressure in the kitchen and staff restaurant. Pressures also noted regarding essential Estates repairs and Laundry.

Medical – Some Medical recharges have now ceased, resulting in an adverse effect, however this is more than compensated being offset with post vacancies, underspends in non-pay, and **Research** underspend to date. **Pharmacy** savings are currently under achieved.

CE – Non-pay expenditure underspends noted.

HR – Vacancy benefits have to date countered staff cost pressures, with benefit noted also from corporate training underspend.

Finance – eHealth cost pressures are noted, with review underway of utilisation/allocation of non-recurring strategic funding received.

Capital Charges – We are awaiting SG confirmation of the required change to the allocation (core to non-core adjustment) – £2.62m being the estimate, with AME provision currently set at p/y value.

Miscellaneous Income (MI) – The budget recognises income billed for exceptional circumstance patients, with appropriate provision for boards with whom recoverable balances are being discussed.

Central reserves – The most significant reserves are inflation / estimate for pay awards held centrally awaiting circular (accrued monthly); PAIAW costs reserve; and Apprenticeship Levy reserve.

4 ASSESSMENT – SAVINGS

The following table summarises the savings set by Directorate.

Cumulative Savings	Savings - Annual Target	Achieved to date / post base adj'ts	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(41)	0	(41)
Finance	(42)	22	(20)
Nursing & AHP's	(347)	465	118
Human Resources	(29)	0	(29)
Medical	(68)	85	17
Security & Facilities	(115)	130	15
Unidentified (phased ytd) - so all 'achieved'	(169)	0	(169)
Total	**(811)**	**702**	**(109)**

While an improved level of recurring saving remains a national / audit focus, it should be noted that of the Hospital's budget only 15% of costs are non-pay related while by comparison, many territorial boards have a non-pay cost element of around 65% and other National boards have non-pay costs ranging from around 80% (NSS, NES) to 30/40%.; while certain boards also treat vacancy savings, or a proportion thereof, as recurring savings.

Savings are phased evenly over the year (twelfths). Draft budgets had unidentified savings currently set at £0.169m; however vacancies are offsetting the gap.

Principle savings achieved to date are from vacancies in Psychology, NPD and Housekeeping, and the savings target for the full year is expected to be achieved in draft outturn for March.

National Boards Contribution

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. The recurring level of contribution to the collective £15m savings challenge which the Board agreed and approved for 2021/22 remained at £0.220m, and this is currently included as forecast for 2022/23.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for 2022/23 is £0.269m. We also have a brought forward unspent 2021/22 allocated project funding for Key Safes & MSRs – this £0.605m was included in our August Allocation schedule – for which work is well underway and completion expected within 2022/23.

In addition, funding has been applied for and received in-year to support backlog maintenance work required on the Hospital site – a range of Estates and Security work was identified and these areas of work are all now included in the planned programme for the current year. A small element of this is revenue work.

With regard to the Perimeter Security Project allocation, there are elements of unforeseen delays in the project – now likely to be completing in early 2023/24 (Q1) – requiring carry forward of unspent monies. SG are fully up-to-date with the anticipated project outturn and conclusion. Payment to the contractor has been negated in recent months due to offset of agreed due penalties.

CAPITAL CRL 2022/2023 AS AT FEBRUARY 2023	ANNUAL PLAN £'k	YTD SPEND £'k
PERIMETER SECURITY		
Stanley Security Solutions LTD		166
Thomson Gray LTD		174
TSH Staff Apr - Sep '22		195
DJ Goode		0
PERIMETER SECURITY TOTAL (Yr 2 of 2)	905	535
CAPITAL		
IM&T	4	26
Other	265	64
MSR refurbishment	400	0
Family Centre gardens	0	87
Key-safes refurbishment	205	0
CAPITAL	874	177
Backlog Maintenance (awaiting funding)		63
Total CRL	1,779	775

6 RECOMMENDATION

Revenue

The year to date position is an underspend of £0.015m, with breakeven anticipated for the year-end.

Capital

CRL June 2022 received £0.874m, with the specific perimeter allocation awaiting the confirmation of the final 2022/23 balance required. We are also awaiting the final confirmed backlog maintenance allocation (previously approved). It is anticipated that our capital allocation will be fully utilised in-year.

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

MONITORING FORM

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

Paper No 23/ 32

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 April 2023
Agenda Reference:	18
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	NIS Review Summary
Purpose of Report:	For Noting

1 SITUATION

The State Hospital (TSH) agreed to a compliance progress review by Cyber Security Scotland during October 2022.

2 BACKGROUND

In 2020 the Scottish Health Competent Authority commissioned a three-year programme of audits and reviews of health boards to evaluate compliance with the Network & Information Systems (NIS) regulations. The initial audit programme has been completed and unless incident reports or significant system changes in a health board merit a more frequent audit exercise, audits shall be conducted every third year. In intervening years, Compliance Reviews are being undertaken – to which this report relates - the primary objective of the review being to review progress on implementing the recommendations from the initial audit and progress on the control requirements.

3 ASSESSMENT AND OUTCOMES

A considerable amount of evidence was submitted up front to the reviewers – each piece of evidence requested for the review being "mapped" to one or more controls set out. The documentary evidence was then reviewed and assessed for compliance.

3.1 REVIEW

The 17 categories of the review were as follows –

- Organisational Governance
- Risk Management
- Supplier Management
- Asset Management
- Information Security Management

- People
- Services Resilience
- Access Control
- Media Management
- Environmental Security
- Physical / Building Security
- System Management
- Operational Security
- Network Security
- Incident Detection
- Incident Management
- Business Continuity

3.2 OUTCOMES

While considerable time and effort was made in preparation for this progress review, and a large amount of documentation provided, it is disappointing to note that there was only limited improvement noted in the controls implementation with 22% achieved or partially achieved, and 5 of 31 previously critical recommendations completed to date – all of which require completion by the deadline of the next full review in late 2023.

In addition, while the compliance status was raised, this was only from 28% to 36%.

While TSH has a strong approach to Information Security, the review highlighted the lack of one individual being in the dedicated post of IT Security Officer, which is seen as a key aspect. Due to the size of our Board and eHealth team, this post is combined with other duties in the role of IM&T Senior Infrastructure Analyst & IT Security Officer – however this is now currently under review.

A significant programme of work is required to be undertaken to reduce this level of risk exposure, and this is now underway as a priority. There were 432 assessment points in total in the review. To date, of the 253 points which were noted as non-compliant across the 17 categories, there are in fact 106 which are identified to have in fact been considered to be compliant, but for which the evidence was insufficient or incorrectly allocated in the submission system.

This would in fact have raised our compliance rating from 36% to 65%, which would have been an acceptable level for this review. However, these were either without the correct “mapping” of available evidence (noted below) or for which, while the procedures / processes are in place as the necessary security is active, the documentation did not adequately evidence.

The programme of work has now confirmed responsibilities across all directorates for provision of documented processes in support of compliance, e.g. business continuity. This is now being allocated to individual specific responsibilities – which will be complete in April for implementation with timed deadlines to June 2023 to ensure compliance by the next review expected in October.

It is noted that –

1 – the review was conducted wholly remotely, and there are elements therein for which it is strongly felt that there would have been clear evidence to support compliance had there been an on-site element to the review. In fact it is essential given the nature of TSH to be able to demonstrate physically a number of areas of compliance which have not been fully understood by the reviewer being limited by documentation only.
These areas are being specifically highlighted both to ensure that the supporting evidence is correctly mapped, and that when reviewers come on site for the next review they can readily be

directed to the compliant physical confirmation. (One example being physical security of offices).

2 – it is now acknowledged that there were elements of documentary evidence submitted for which the full "mapping" was not adequately linked – e.g. where one piece of evidence would support multiple categories or targets, it was only mapped to one item, thereby negating the others. The process for this mapping is now being revised to ensure this does not recur.

Progress is therefore underway, with an agreed resource and time commitment to ensure compliance levels are attained in 2023, and is being monitored by the Director of Finance and eHealth, Head of eHealth, and IT Security Officer.

3.3 NEXT / CURRENT STEPS

The identified areas for action have now been collated as planned, and are being allocated to specific directorate responsibilities for action to be underway.

Of the 147 individual actions for which there is currently no evidence and which are therefore the key areas, the main sectors to be addressed are –

- Organisational Governance – 14
- Risk Management – 13
- Information Security Management – 11
- Access Control – 9
- System Management – 10
- Operational Security – 10
- Network Security – 9 *(down from 11)*
- Incident Management – 13
- Business Continuity – 30

Each outstanding action is allocated a responsible individual / dept., which is currently being finalised and notified to all relevant staff by 30 April, together with a structured template for each action to be addressed, documented and then submitted for collation into the main audit submission.

These actions will be tracked fortnightly thereafter by the monitoring group (Director of Finance & eHealth, Head of eHealth and IT Security Officer). The Corporate Management Team has oversight with monthly reporting on progress, as well as monitoring the risk as part of the Corporate Risk Register.

Each action will have a completion date agreed – at the latest 30 June. At this point they will be appraised and verified, in order that the overall tracked action plan will be ready for the next independent review in Autumn 2023 (date in October tbc).

4 RECOMMENDATION

The Board is to note the report, the follow-up actions being taken forward, and that in-year progress will be reported to future meetings.

Paper No 23/ 32

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	N/A
Workforce Implications	N/A
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations	eHealth subgroup, IGG CMT
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)	
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:	27 April 2023
Agenda Reference:	Item No: 19
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Director of Security, Resilience and Estates
Title of Report:	Centralised Visiting - Update
Purpose:	For Noting

1 SITUATION

As part of The State Hospital's (TSH) response to the Covid-19 pandemic, the interim centralised visiting model was implemented in July 2020, using the Family Centre to support prevention and control of infection. The Family Centre was designed to provide a balance between security and child protection and facilitates visits for patients and family with prior approval by the clinical team. Following positive feedback on the interim model a request was made to the Corporate Management Team (CMT) to purpose the centre as the main visiting area for the hospital with visiting for patients with more complex needs continuing to be facilitated within the ward environment.

2 BACKGROUND

Visiting has historically taken place within the ward environment, facilitated by nursing staff. Considerable feedback has been shared by stakeholders indicating that this environment is not always conducive for visits. There have also been numerous requests for access to outdoor space for visiting when weather permits. Additionally, Scottish Government Person Centred Visiting guidance calls for a more tailored approach to meeting individual needs, advocating the need to ensure that visiting environments are fit for purpose and embrace the concept of 'open visiting', which enables family and friends to be more involved in the delivery of care, including spending mealtimes together.

Following the request to CMT to re-purpose the Family Centre, a risk assessment highlighted that additional security control measures would be required to ensure that centre was fit for purpose and all relevant risks had been highlighted and appropriate control measure were in place in line with the hospital's Risk Management Strategy.

The CMT commissioned a short life working group remitted to identify and assess any long term risk in using the Family Centre,as well as maintaining and improving security and defining costings for implementation. The group consisted of:

Responsible Medical Officer (Lead)
Head of Estates and Facilities
Head of Security
Head of Risk and Resilience
Estates Officer
Person Centred Improvement Lead

3 ASSESSMENT

Initial assessment identified adaptations with an estimated cost of £100k, however following a Fire Risk Assessment the security proposal was adapted resulting in a new plan with reduced costs of £75k.

A capital budget has already been allocated to upgrade the Family Centre garden, supporting wider use of the outdoor environment for visiting and this work has been completed.

The required security enhancements have now been implemented to support the new access/egress and management of the area during visits including additional electronic locking mechanisms and CCTV.

The programme of works was completed by 31 March 2023 at a final cost of £65,461.49.

4 RECOMMENDATION

The Board are invited to note completion of the Capital works.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports delivery of person-centred service delivery objectives.
Workforce Implications	
Financial Implications	Additional budget required for capital costs.
Which groups were involved in contributing to the paper and recommendations.	SLWG, Board requested
Risk Assessment (Outline any significant risks and associated mitigation)	
Assessment of Impact on Stakeholder Experience	Responds to stakeholder feedback reporting improved visiting experience within the Family Centre.
Equality Impact Assessment	Not required. Family Centre more accessible for those with mobility issues.
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 implications.
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:	27 April 2023
Agenda Reference:	Item No: 20
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Programme Director
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
Purpose of Report:	For Noting

1. SITUATION

This report to the Board summarises the current status of the Perimeter Security and Enhanced Internal Security Systems project. Board members are asked to note the overall project update, the financial 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 Project Oversight Board meets monthly. The POB last met on 24th April 2023 and is scheduled to meet again on 18th May 2023.

The Programme Director provided an update on the current status on the project, the Project Risk Register and financial details.

3. ASSESSMENT

a) General Project Update:

The project is in the final stages. All quality targets are being met; project timescales have moved to completion in September and costs are projected to overspend by approximately 4%.

b) Project Timescales

Programme revision 45a was previously accepted with Caveats and an end date of 28th July 2023. Further revisions have been reviewed and rejected. Revision 47 is currently under review. It has a forecast contract completion of 8th September.
The installation of technology is substantially complete, though some critical areas remain. Full completion of the main technological elements of the project (prior to commissioning and Site Acceptance Testing) is forecast for mid June.

c) Finance – Project cost

The project is proceeding according to the current projected cost plan.

The key project outline at 15th April 2023 is:

Project Start Date:	April 2020
Planned Completion Date:	September 2023 (draft prog. Rev 47)
Contract Completion Date:	April 2022
Main Contractor:	Securitas Technology Limited
Lead Advisor:	Thomson Gray
Programme Director:	Doug Irwin
Total Project Cost Projection (Exc. VAT) at 15/04/23:	£9,140,676
Total costs to date (exc. VAT) at 15/04/23:	£8,425,799
Total costs to end of project (Exc. VAT, Inc. Retention)	£ 714,877

The cash flow schedule planned for the months to come is confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our SG funding drawdown is scheduled accordingly. All project payments are processed only once certification is received confirming completion of works to date.

While it is not a prerequisite of the project, regular reports to the SG Capital team are also being provided to notify of progress against total budget.

50% of the 5% retention is due to be paid at completion, with the remaining 50% to be paid at the end of the defects and liability period of 2 years.

A Rounded breakdown of actual spend to date (Exc. VAT) at end of March 2023 is below.

Securitas	£ 6.843m (5% retention applied)
Thomson Gray	£ 0.858m
Doig & Smith	£ 0.008m
HVM	£ 0.150m
Staff Costs	£ 0.649m
Income	-£ 0.083m
Total	**£ 8.426m** (Corrected for roundings)

VAT has been excluded from calculations of amounts paid due to the need for the reclaim to be applied for and assessed.

4 RECOMMENDATION

That the Board **note** the current status of the Project

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Update paper on previously approved project
Workforce Implications	N/A
Financial Implications	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

AUDIT COMMITTEE

Minutes of the meeting of the Audit Committee held on Thursday 26 January 2023.

This meeting was conducted virtually by way of MS Teams, and commenced at 09.15am.

Chair:	
Non-Executive Director	David McConnell
Present:	
Non-Executive Director	Stuart Currie
Employee Director	Allan Connor
Non-Executive Director	Pam Radage
In Attendance:	
External Auditor, KPMG	John Blewett
Internal Auditor, RSMUK	Victoria Gould
Chief Executive	Gary Jenkins
Internal Auditor, RSMUK	Asam Hussain
Director of Workforce	Linda McGovern [Item 11]
Director of Finance and eHealth	Robin McNaught
Board Chair	Brian Moore
Board Secretary	Margaret Smith
Director of Security, Estates, and Resilience	David Walker
Personal Assistant to Corporate Services	Julie Warren [Minutes]

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting, and apologies were noted from Monica Merson, Head of Planning and Performance and Mr Michael Wilkie, External Auditor from KPMG.

It was acknowledged that this was the first Audit Committee meeting for the new external auditors and a warm welcome was extended to Mr John Blewett from KPMG, including a round of introductions.

Members were also advised that internal auditors would be asked to step out of the meeting for item 19; Provision of Internal Audit Service.

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 29 September 2022 were noted to be an accurate record of the meeting.

The Committee:

1. Approved the minute of the meeting held on 29 September 2022.

4 MATTERS ARISING – ACTION PLAN UPDATE

There were no additional urgent matters which arose for discussion.

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

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

The Committee:

1. Noted the updated action list.

INTERNAL AUDIT

5 INTERNAL AUDIT FOLLOW-UP/PROGRESS REPORT

a) Mr Asam Hussain, and Ms Vicky Gould of RSMUK provided an overview of the Key Financial Controls Report dated 17 January 2023. Members noted the overall conclusion was 'reasonable assurance' that controls upon which the organisation relied to manage the area were suitably designed, consistently applied and effective. The key findings were also considered in detail, as well as the planned actions.

Ms Radage thanked internal audit for the positive report and commented on the challenges of segregation of duties required given the size of the Board.

Mr McNaught welcomed the report and thought the review at this point in time was useful, and he concurred with the items identified for further progress. He echoed the point made by Ms Radage in terms of the challenges of being a small team in the context of the segregation of duties required.

Mr Currie further commented on the size of the organisation and the consistency of training required to be delivered to new members of staff. It was thought to be a good opportunity to expand on best practice. Lastly, he expressed the view that the report was positive, impactful and was of real value.

The Chair acknowledged that this system was part of broader arrangements (and audit reviews) across the NHS including in NSS and queried how the work would link in with that at NHS Ayrshire and Arran and NSS to ensure no review had fallen between areas over the system. Mr Hussain reassured the Committee that NSS auditors would review the system and test the transaction from clients they service, therefore this report should be read in conjunction with the NSS report, which was expected to be received in June 2023 and would be shared with members when available.

Mr McConnell made reference to the large volume of journals and queried whether there might be any potential patterns emerging. Ms Gould advised that during the run through, detail testing was discussed with management. Suggestion was made to external audit taking this forward. She further advised that if further data analytics were required, she could help in this area.

b) Members received and noted the Internal Audit Progress Report dated 26 January 2023. The report provided an update on progress against the plan and summarised the results of the work to date. One final and one draft report were issued since the last meeting i.e. Key Financial Controls, which received reasonable assurance, and Workforce Planning and Rostering, which should receive partial assurance (currently in its draft form).

For noting purposes, two audits were delayed due to external factors, with the Security Resilience audit deferred to Spring 2023 due to revised timescales for the security project and the delays to the implementation of the clinical model which impacted on the timing of this audit. This had previously been reported to and been approved by the committee. These two audits were replaced by a payroll audit and a performance management audit which remain in the process of being completed. It was also noted that RSMUK continued to track progress of previously agreed internal audit management actions and provided a status update on actions in their separate report as part of the agenda.

Mr Hussain advised that the workforce and rostering report was issued though not finalised for inclusion in today's agenda. Once finalised this would be shared with the Committee rather than waiting until the next meeting.

Action: Mr Assam Hussain

The Chair advised he was content to note the report and looked forward to having sight of the workforce and rostering plan as noted above.

The Committee:

1. Noted the Key Financial Controls Report dated 17 January 2023 and the Internal Audit Progress Report dated 26 January 2023.

6 INTERNAL AUDIT TRACKING REPORT

Members received and noted the Internal Audit Management Actions Tracking Report dated 12 January 2023.

Mr Hussain advised that of the 11 actions still live on the tracker, all became due following updated implementation dates, since the last Audit Committee. From the follow up work this time, one action had been implemented, with six remaining ongoing following detailed updates from management on the current position. Three of these ongoing actions related to actions from the Clinical Observations audit, where, after a change in directorate lead, changes were being implemented around the new Clinical Care Policy. The remaining three related to the eHealth audit, whereby the eHealth Plan and subsequent IT Strategy were still in the process of being finalised. The four actions around Rostering were superseded due to the recent audit covering off areas where previous management actions were agreed, and with the change in directorate lead, significant change was being planned in this area and therefore new actions will supersede previous actions to provide a more up to date picture.

Mr Currie queried whether detail of work progressed could be reported during the period of extension requested. Ms Gould advised that contact was made with responsible directors and auditors were content with the updates provided.

Mr McConnell noted that the majority of revised dates were sitting at 31 April 2023 and questioned whether the Committee were content with these timescales. Mr Jenkins advised that timescales were felt to be appropriate with Executive leads giving consideration to the work required and the move to the new clinical model.

The Committee:

1. Noted and approved the changes to the Internal Audit Management Actions Tracking Report dated 12 January 2023.

INTERNAL CONTROL AND CORPORATE GOVERNANCE

7 CORPORATE RISK REGISTER UPDATE

The Committee received and noted the Corporate Risk Register update which was presented by Mr Walker and who provided an overview and update on each corporate risk.

Mr Currie expressed the view that the report was in line with the updates to the Board and other committees and was therefore content to accept.

Ms Radage commented that the report had evolved and was more practical in nature. In terms of risk HRD111 (Deliberate leaks of information) she queried the timing aspect and review date of

mitigating actions, as it was important to mitigate against this risk as soon as possible. Mr Walker advised he would take this action forward with the Director of Workforce for clarity. Mr Jenkins provided further detail in terms of identification of the source and reasoning behind the escalation of the risk.

Action: Mr David Walker / Ms Linda McGovern

In terms of CE15 (Impact of Covid 19 Inquiries), and as Hospital lead for the Covid-19 UK and Scottish Inquiries, Ms Smith advised that other NHS Boards sought contact to share the hospital's Business Manager Job Description. This was recognised as a positive step. Mr McConnell queried how the hospital were liaising with other Boards in relation to the Inquiries and if there were mechanisms in place for this. Ms Smith advised that herself and Mr Jenkins remain closely linked with Boards in taking forward the work and responding to the first request for information. Mr Jenkins further advised that Chief Executives were continuously briefed.

The Chair thanked Mr Walker and his team for the overall, positive report.

The Committee:

1. Reviewed and noted the Corporate Risk Register as an accurate statement of risk, and

2. Agreed no additional information was required for future reports given the usefulness of its current form.

8 FRAUD UPDATE

The Committee received and noted the Fraud report which provided an update on fraud allegations and notifications received from Counter Fraud Services.

Mr McNaught provided an overview of the report and the Committee raised no specific concerns. Members noted the alerts circulated by Counter Fraud Services in the last quarter and noted the nil update on fraud allegations within the hospital.

The Committee:

1. Noted the Fraud update for the period of the last quarter.

9 FRAUD ACTION PLAN

Members received and noted the Fraud Action Plan which included an update on the Board's approach to countering fraud. Mr McNaught provided an overview of the report in terms of the activities used to gauge Counter Fraud Services' (CFS) level of engagement with each Board and that these activities would be the basis of discussion during their annual customer engagement visit.

Mr McConnell queried the timings in the narrative on page two and whether this required updating. Mr McNaught advised the narrative would be updated in future reporting.

Action: Mr Robin McNaught

The committee noted the progress on engagement activities as well as the update on Communication. Members reviewed the Fraud Action Plan statement from CFS and noted no further revision to the Top Ten Risks identified from the FRAM (Appendix 2).

The Committee:

1. Noted the Fraud Action Plan.

10 CYBER SECURITY CRIME REPORT

Members received and noted the Cyber Security and Awareness Activities update which was presented by Mr Robin McNaught. In summary, he advised that there were no national alerts reported by NSS, and that there were two incidents locally which were contained and dealt with appropriately. He advised that the State Hospital continue to work closely with national teams and there were no issues to raise. The hospital also benefit from effective communication and guidance issued to staff from the eHealth team to maintain focus on potential risks.

The Committee:

1. Noted the Cyber Security Crime Report.

11 ATTENDANCE MANAGEMENT REPORT

The Committee received and noted the Attendance Management Report on overall workforce performance to 31st December 2022 and the Workforce Report for January 2023.

Mrs McGovern provided a detailed summary of both reports and provided an overview on absence and attendance management, recruitment, supplementary staffing, employee relations, staff turnover and PDPR compliance data up until 31 December 2022. Ms McGovern further advised that the Workforce Governance Group were focusing on and taking forward a piece of work around staff turnover and workforce retention. Also, that the recent work ensuring QR codes were available to capture exit interview information had proved successful.

Mr Connor queried the accuracy of the workforce establishment band three ward nursing staff estimated figure given that the hospital had recently oversubscribed in this area, to support overall staffing. Ms McGovern advised that nursing staff new starts would be reflected in the January 2023 figures and would therefore be presented in the next report to the Committee.

Mr Jenkins queried whether the Committee found the full report helpful as it was also routinely routed through the Staff Governance Committee. Ms Smith advised that this was a historic practice to reflect associated risk with management of attendance, though that members may wish to reconsider this position.

Mr McConnell highlighted that he was not a member of the Staff Governance Committee and would therefore welcome any relevant data to Audit for review. In particular, he noted key issues around financial implications of absence and workforce recruitment as these would be helpful to review and evaluate costing implications. He recognised the benefit of also having the seasonally adjusted position, having removed covid-19 and influenza figures. Ms McGovern advised this information would be pulled together and contained within the next report submitted to the Committee.

Action: Ms Linda McGovern

Ms Radage raised the potential for duplicate reporting at two Board Committees though agreed that financial points would be of relevance for Audit members to review.

Mr Hussain echoed that he would welcome workforce data from a risk point of view given this was a risk on the Corporate Risk Register and part of the Committee standing agenda.

Mr Jenkins suggested that he, alongside Mr McNaught, review the costings aspect as discussed above and the possibility of incorporating this in to the Finance update report to the Committee to provide a more detailed analysis in terms of workforce.

Action: Mr Robin McNaught / Mr Gary Jenkins

The Chair welcomed the helpful extensive report and its wealth of data. He suggested a review of future data submitted to the Committee with key individuals, to establish the reporting format, data required, as well as identifying clear actions for the Committee, if appropriate.

Action: Ms Linda McGovern

The Committee:

1. Noted the Attendance Management Report, and

2. Agreed to take action as recorded above in terms of future reporting on workforce.

12 AUDIT UPDATES

a) ICO

Members received and noted the Information Commissioner's Officer Audit Summary, which was presented by Mr McNaught. He advised of the follow-up actions required following the audit conducted between 7 and 21 November 2022. He further advised of the significant amount of preparatory work carried out and positive discussions held with the reviewer and acknowledged the positive feedback received. The rating for the State Hospital was "High" indicating that a high level of assurance had been achieved.

Mr Currie stressed the importance of preparatory work and that a self-assessment process was helpful in improving our own awareness. Mr McNaught noted that the audit had demonstrated the good structures in place through the Information Governance Group. Mr Jenkins also reiterated this point around the benefit of heightened, collaborative focus and ensuring a plan was in place.

The Committee:

1. Noted the summary update from the Information Commissioners Office.

b) NIS

Members received and noted the Network and Information Systems update for which Mr McNaught gave a detailed overview. He acknowledged the disappointing outcome from the review but noted that this was an interim review, with the next audit to take place in autumn of this year. He highlighted two main areas, recognising that the input provided by TSH had not demonstrated areas of compliance, and this required more work to be progressed internally. Secondly that as the review had not involved coming on site, some aspects around security has not been fully recognised. In future, the audit would take place on site.

Mr McNaught also advised that from a procedural element, there was no opportunity to provide feedback or to discuss findings and rating. He acknowledged that overall, there were lessons to be learned from this, and that he would ensure that this was taken forward along with the Head of eHealth. A monthly update would be provided to the Corporate Management Team, and a further update brought back to this committee.

Action: Mr Robin McNaught

Mr Jenkins expressed his disappointment in the outcome and echoed Mr McNaught's comments around on-site reviewing. and acknowledged the clear issue of how the hospital submits evidence. He referred to a letter from the Deputy First Minister which referred to cyber security challenges underlining the importance of this area, and setting out clear expectations of Boards. Mr McNaught agreed to circulate this letter to Non-Executive Directors for awareness.

Action: Mr Robin McNaught

Members recognised the areas to address and to improve alongside the lessons learnt, particularly the need for development in this area.

The Committee:

1. Noted the Network & Information Systems update.

EXTERNAL AUDIT

13 AUDIT PLANNING 2022/23

The Chair welcomed Mr John Blewett, Engagement Manager from KPMG to his first meeting of the Audit Committee. It was noted that Mr Michael Wilkie, Director of Audit, was unavailable to attend today's meeting but would wish to attend future meetings. A brief introduction on the audit work was provided and members noted that Mr McNaught had met with external audit colleagues prior to the meeting to introduce and discuss the wider scope requirements going forward. Mr Blewett advised that a handover with outgoing auditors Azets would take place shortly. Initial requests by the auditors for key financial and related information had produced a good response. In terms of planning and risk assessment, a full annual audit plan would be submitted to the Committee in March in line with the new audit cycle.

Action: Mr John Blewett

Members formally welcomed and thanked Mr Blewett for the helpful update and advised they looked forward to receiving the audit plan at the next committee meeting.

The Committee:

1. Noted the verbal update from external audit, KPMG.

14 PUBLIC AUDIT IN SCOTLAND

Mr McConnell and Mr McNaught advised of two pieces of work that they were involved in regarding Public Audit in Scotland. Firstly, a request was received to capture views on the quality of external audit, provided by outgoing auditors Azets, in the form of an online survey. Secondly, the Chief Operating Officer of Audit Scotland requested participation in their survey 'Public Audit in Scotland', to capture thoughts on Audit Scotland's future strategy and further developments in public sector external audit.

McConnell advised that both requests for information were fed back to Audit Scotland with positive responses.

The Committee:

1. Noted the verbal update in terms of Public Audit in Scotland.

NATIONAL REPORTS

15 AUDIT SCOTLAND NATIONAL REPORTS

It was noted this was a recurring agenda item, relating to reports with a specific relevance to the State Hospital, though there was a nil report for this meeting..

The Committee:

1. Noted the nil return in terms of specific national reports.

INTERNAL UPDATES FOR INFORMATION

16 SECURITY, RISK AND RESILIENCE, HEALTH AND SAFETY GROUP UPDATE

Members received and noted the Security, Risk and Resilience, Health and Safety oversight group update, which Mr Walker provided an overview. No issues or concerns were raised.

The Committee:

1. Noted the Security, Risk and Resilience, Health and Safety oversight group update.

17 FINANCE, EHEALTH AND AUDIT GROUP UPDATE

Members received and noted the Finance, eHealth and Audit Group update as was presented by Mr McNaught. Members noted the report content and recognised no areas of escalation were required.

The Committee:

1. Noted the Finance, eHealth and Audit Group update.

18 ANY OTHER BUSINESS

There was no other business. The Committee then agreed to convene privately to review internal audit provision.

19 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Thursday 6 April 2023 at 9.15am via MS Teams.

End of meeting 1215 hours.