THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 26 APRIL 2018
9.45am

The Boardroom, The State Hospital, Carstairs, ML11 8RP

A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes**		
	To submit for approval and signature the Minutes of the Board meeting held on 15 February 2018	For Approval	TSH(M)18/01
4.	**Matters Arising:**		
(a)	**Actions List**	For Noting	Paper No. 18/12
5.	**Chair's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
6.	**Patient Story The Patient Partnership Group River Journey: ebb and flow**	For Noting	Presentation
7.	**Planning for Long Term Service Sustainability** Report of the Director of Nursing & AHPs	For Noting	Paper No. 18/13
8.	**Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 – Update Part 4** Report of the Director of Nursing & AHPs	For Noting	Paper No. 18/14
9.	**Duty of Candour – Update** Report of the Medical Director	For Noting	Paper No. 18/15
10.	**Nursing Resource Utilisation Group – Update** Report of the Finance & Performance Management Director	For Noting	Verbal
11.	**Clinical Governance Committee**		
	• Chair's report	For Noting	Verbal
	• Draft Minutes – 22 February 2018	For Noting	CG(M) 18/01

STAFF GOVERNANCE

12.	**The National Health and Social Care Staff Experience Report** Report of the Interim Human Resources Director	For Noting	Paper No. 18/16
13.	**Staff Governance Committee – Update** • Chair's report	For Noting	Verbal

CORPORATE GOVERNANCE

14.	**Finance Report as at 31 March 2018** Report of the Finance & Performance Management Director	For Noting	Paper No. 18/17
15.	**Summary Report on Savings Action Plan** Report of the Director of Nursing & AHPs	For Noting	Paper No. 18/18
16.	**Draft Annual Operational Plan** Report of the Finance & Performance Management Director	For Noting	Paper No. 18/19
17.	**Annual Review of Standing Documentation** Report of the Finance & Performance Management Director	For Approval	Paper No. 18/20
18.	**Project Bank Account** Report of the Finance & Performance Management Director	For Approval	Paper No. 18/21
19.	**Audit Committee – Update**		
	• Chair's Report	For Noting	Verbal
	• Approved Minutes – 18 January 2018	For Noting	A(M) 18/01
20.	**Chief Executive's Report**	For Noting	Paper No. 18/22
21.	**Any Other Business**		

DATE & TIME OF NEXT MEETING

22. Thursday 28 June 2018, 9.45am in the Boardroom, at The State Hospital, Carstairs ML11 8RP

23. EXCLUSION OF PUBLIC AND PRESS

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

TSH (M) 18/01 - Minutes: 1-17

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 15 February 2018 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Chair:	Terry Currie
Present:	
Non Executive Director	Bill Brackenridge
Non Executive Director	Elizabeth Carmichael
Employee Director	Anne Gillan
Non Executive Director	Nicholas Johnston
Non- Executive Director	Maire Whitehead
Chief Executive	James Crichton
Finance and Performance Management Director	Robin McNaught
Medical Director	Lindsay Thomson
In attendance:	
Training & Professional Development Manager	Sandra Dunlop (For Minute 7)
Security Director	Doug Irwin
Head of Communications	Carline McCarron
Patient Learning Manager	Julie McDonald (For Minute 7)
Board Secretary	Margaret Smith
Deputy Security Director	Nicola Watt
Interim HR Director	John White

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Currie welcomed everyone to the meeting, and apologies were received from Ms K Blessing.

NOTED

2 CONFLICTS OF INTEREST

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

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 14 December 2017 were noted to be an accurate record of the meeting, subject to minor amendment in the listing of those present and in attendance.

NOTED

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

There were three actions noted from the last meeting, and progress was being made on each.

NOTED

5 CHAIR'S REPORT

Members noted an update from Mr Currie on the main issues discussed at the most recent NHS Scotland Chairs Meeting which had taken place on 29 January 2018.

In 2018, the NHS would be 70 years old and a six week campaign would commence on 21 May in the lead up to the anniversary date of 5 July - with four themes to commemorate the event: Innovation, Caring, Evolving and People. Mr Currie highlighted the opportunity for The State Hospital (TSH) to make a contribution, and noted that it was also the 70th anniversary of TSH at this site.

Mr Richards confirmed that the Skye Centre would investigate how to involve patients through therapy with invitations to themed learning in commemoration of the event. He also updated the Board on involvement from a nursing perspective to a national initiative to capture nursing stories throughout the years within the NHS. Ms McCarron confirmed that she would provide support to ensure awareness of, and compliance with, national branding guidelines.

At the NHS Chairs Meeting, Christine McLaughlin, Director of Finance at Scottish Government Health Directorate (SGHD) had updated the group in regard to the 5-year Financial Plan and confirmed that a paper would be circulated shortly. She had confirmed that the £15m savings required from the National Boards would be recurring going forward.

Mr Currie noted that Paul Gray, Chief Executive NHS Scotland, had highlighted the pressures experienced in NHS Scotland during December 2017 and January 2018; particularly the changing nature of demand and how the decision-making framework could evolve to accommodate this. The Cabinet Secretary, Shona Robison, was in attendance and had added her strong and sincere praise for how staff had responded to a challenging situation. She had also noted the agreement on the new General Practitioner (GP) contract, which would necessitate re-design of the way in which primary care services were delivered. There would be continuing discussion with GPs around the service on public holidays. She also recognised that further discussions would take place regarding issues in rural practices Ms Robison had also underlined the need for the NHS to achieve a higher take-up by staff for the flu vaccine.

The Cabinet Secretary had highlighted to Chairs that the Draft Budget published in December 2017, represented a £354m (3.7%) increase to front line Boards. Mr Currie noted that this would result in a 1% increase to National Boards.

The Mental Health Minister, Maureen Watt, had also been present and had expressed concern at the slowness of progress toward meeting mental health targets – with £54m investment made this year. Ms Watt would be meeting with individual Chairs to take forward discussion in this regard.

It was noted that Dr Harry Burns would be in attendance at the March 2018 meeting of NHS Chairs. The group had received a presentation from Tim Davidson, Chief Executive NHS Lothian, on the East Region [comprising Borders, Lothian and Fife] which had served to underline some of the key challenges facing the NHS and the extent of the transformational change required to meet these challenges.

Mr Currie reported to the Board that the Cabinet Secretary had re-appointed Mr Bill Brackenridge and Mrs Maire Whitehead as Non-Executive Members of the Board until 31 January 2021. This would extend their period of appointment to the maximum of eight years.

Non-Executive Members were informed that the Board Secretary, Ms Smith, would contact them in the near future to arrange appraisal review interviews with the Chairperson.

Mr Currie reported that he had attended the Public Body Board Members Finance Workshop on 31 January 2018, along with Mrs Carmichael. He commended it for giving a good insight into the overall financial position of Scottish Government. There were a number of emerging risks associated with achieving greater financial autonomy and these were clearly highlighted. It was also apparent that there was no sign of the financial pressure on public expenditure easing. It had been noted that NHS Scotland now accounted for 41% of the overall public budget.

NOTED

6 REQUEST FOR SECTION 22 APPROVAL

A report was received from the Medical Director which asked the Board to agree Approved Medical Practitioner Status of Dr Jana De Villiers following her recruitment to the Board as Forensic Psychiatry Learning Disability Doctor. This would be in line with the Mental Health (Care and Treatment) (Scotland) Act 2003.

This was agreed and the Medical Director would arrange for Dr De Villiers to be formally placed on The State Hospital's list of Approved Medical Practitioners.

Action – Professor Thomson

AGREED

7 PATIENT LEARNING – ANNUAL REPORT

The Annual Report for Patient Learning was submitted to the Board, on behalf of the Interim Director of Human Resources, which asked the Board to note detail of service activity levels and key achievements for the period January to December 2017. The report also highlighted the challenges and future developments for the service in 2018.

Ms Dunlop and Ms McDonald were in attendance to present the paper. Ms Dunlop led Members through the key highlights of the report, noting that 62% of patients were engaging in formal learning, an increase in capacity uptake as well as a reduction in non-attendance at sessions. The service was offering a new creative art qualification, and was also developing work-based roles in the patient library for patients with learning disability – providing opportunity for these patients to engage in some aspects of the role depending on their individual capacity and needs. She also highlighted that there had been an increase in one to one interventions with patients.

Some of the key challenges for the service in 2018 would be around staffing (particularly the current vacancy for a gardener) as well as progress required on eHealth with an IT upgrade expected to be delivered in April 2018. The Awards Ceremony marking patient achievement had taken place on 7 February 2018 and had been attended by the Chair. It was noted that it would be helpful for all Non-Executives to receive invitations to the ceremony, and Ms Smith would ensure that this was the case.

Action – Ms Smith

Mr Currie thanked Ms Dunlop and Ms McDonald for providing a very clear report, and Mr Richards echoed this. Mr Richards welcomed the inclusion of patient feedback as a positive addition to the report, as well as acknowledging that a patient network had been in planning stages. Ms Dunlop clarified that this had not been deferred, but was included within the Workplan for delivery in April 2018. Mr Richards also asked if the figures provided for core skills screening could be presented

as numbers rather than in percentage terms as this would allow identification of patients who went on to learning, as well as any deficit.

Action – Ms Dunlop

Mrs Carmichael welcomed the report and the impressive work of the service, which had evidenced growth throughout the past year. She asked for some assurance in relation to the soft landscaping small animal care projects, especially in respect to any potential to lose access to SQA qualifications for patients. Ms Dunlop confirmed that despite efforts being made to recruit to the position of gardener, this had to date been unsuccessful and also agreed that it would be regrettable to lose learning opportunities. She added that the service made every effort to balance learning opportunities across areas, keeping the contribution of each to patient learning at the centre of decision–making in service delivery. Ms McDonald acknowledged that it would be beneficial for progress to be made on timetabling learning sessions to try to ensure that patients were not already attending other disciplines within the hospital site as part of their care.

Mr Johnston commented that this was a positive report which clearly demonstrated that the service was busy but effective. He asked for further detail around the figures for non-attendance which showed an increase in patients not attending learning sessions due to their mental state or physical condition.

Action – Ms Dunlop

Professor Thomson noted the link between motivation and health issues, and Ms McDonald advised that sometimes attendance on the part of individual patients could be erratic due to short term issues. In these instances, the service thought that it was important to support patients though these periods and to ensure that erratic short term attendance patterns did not mean that they were removed from placements. Mr Johnston was reassured by this in that reaching these patients with mixed success was evidence of the right approach.

Ms McDonald provided further clarification that the report recorded the main reason for non-attendance on the part of a patient She also acknowledged that some of the non–attendances were due to one off meetings for patients being arranged in such a way that there was a clash with a learning session and that better planning would reduce this issue. Mrs Whitehead noted that there had been a reduction in the number of patient refusals which was a positive development.

Professor Thomson thanked the service for a very positive report and wished to highlight how this progress could be developed further in 2018. In relation to the data provided for core learning skills, she thought that it may be helpful to separate the figures for the patient population in Iona 2, as well as for other patients with intellectual disabilities as this patient cohort had requirements that would differ from the rest of the patient population. This would provide more clarity in the rates of core learning skills.

Action – Ms Dunlop

Professor Thomson asked how the service was linking into the rest of the Forensic Network in terms of medium and low secure sites, when patients are transferred on from TSH. Ms McDonald confirmed that the service did meet regularly with occupational therapists from other sites to ensure a cohesive approach was in place for patient transfer. When a patient moved to another site, his patient learning certificates would move with him. If a patient was engaged in learning from an external provider e.g. the Open University, this learning would continue after transfer.

On occasion, there may be a break in learning for the patient if the timetabling of TSH learning was not in synch with those of other sites. However, all of the courses available in TSH were also available in medium secure sites (other than some vocational courses) and so the patient would be able to continue with his learning in most areas.

Mr McNaught added that in relation to the IT upgrade for a patient network, there was a clear

commitment to this for the coming year.

Mr Currie noted the positive input received from The Open University as a very positive development for TSH. Whilst noting the constraints and challenges faced by the service, he thought that the service had made great progress and wished to recognise this achievement. Mr Currie requested that the Board be kept informed about progress in relation to the vacancy for a gardener especially given the potential for a reduction in therapeutic assistance and SQA accreditation. Mr Richards would ensure that this was the case.

Action – Mr Richards

In respect of eHealth there had been agreement around the table that it would be valuable for the Board to have more visibility in this area in the short term to ensure that focus is retained. Mr Crichton agreed that it would be helpful for a paper to be brought to the Board by June 2018 at the latest. Mr McNaught confirmed that funding for the IT upgrade would be required from both the capital and staffing budgets.

Action – Mr McNaught

NOTED

8 STAFF GOVERNANCE COMMITTEE MEETING HELD ON 30 NOVEMBER 2017

The Board was asked to note the draft Minutes of the Staff Governance Committee meeting held on 30 November 2017. These minutes would be brought to the next Staff Governance Committee for approval.

The Chair of the Committee, Mr Brackenridge, emphasised that at the time of this meeting the position on staff attendance had appeared positive and moving in the right direction. He also noted that although there had been an increase in staff absence in December 2017/ January 2018, the data still represented an improvement on the data for the same period 12 months ago. Mr Currie added that it was essential for the focus in this area to be general across all directorates and disciplines at TSH, and Mr White provided assurance that this was the case.

NOTED

9 FINANCE REPORT AS AT 31 JANUARY 2018

The Finance Report was submitted to the Board as at month ten (to 31 January 2018) by the Director of Finance, and Members were asked to note the content of this report. Mr McNaught led Members through the report highlighting the key areas of focus.

The Board was in an overspend position £0.378m. Although an overspend position was to be expected at this point in the financial cycle, this was greater than expected and compared to an overspend position of £0.120m at the same point last year, meaning a forecast overspend at the end of January of £0.250m. Within individual budgets, the main variance continued to be nursing costs and overtime within the General Manager Directorate. Ward nursing had an adverse variance of nearly £300k higher than at the same period last year. Overtime in December and January alone had showed an increase of around £130k from 2016/17 and this had contributed significantly to the current position.

Following the rise in overtime costs in December 2017 and January 2018, a savings plan had been agreed by the Senior Management team and put into being for the last seven weeks of the financial year. A number of specific steps had been taken to ensure that the nursing spend in the last two months (seven weeks) of the financial year reduced to a level that was sustainable within the current year budget and enabled financial breakeven. Mr McNaught emphasised that this plan

should make a significant contribution to reducing overtime costs.

Mr McNaught advised Members that reviews of individual budget savings plans was continuing with the focus remaining on reducing any element of unidentified savings and to reduce the proportion of non-recurring savings – with initial work focused on the 2018/19 Directorate budgets.

The paper also noted work being progressed to address the additional £440k savings required as part of the National Boards' £15m overall savings requirement instructed by the Scottish Government Health Directorate. Finally, the capital resource budget was anticipated to be fully utilised in 2017/18.

Mr Currie sought clarification on what had occurred at a local level to cause the deviation from the previous forecast provided to the Board in December 2017 and asked whether, collectively, it would it have been possible to have raised more questions about the projection and thus have been in a position to have taken action sooner

Mr Richards outlined the key factors – there had been a rise in sickness absence in December 2017 in the lead up to and during the seasonal period. There had also been exceptional pressure from a clinical perspective which had required additional staffing to ensure appropriate staffing cover was in place. Mr McNaught added that the previous forecast had been based on the experience of staffing levels during previous years - this year's staffing needs had been unprecedented. Mrs Whitehead asked for further background in relation to the clinical activity and Mr Richards explained that there had been an unusually high number of patients who required increased observation. In addition, during December and January there had also been an increase in offsite activity, most notably general hospital visits for patients and this had also contributed to the increased pressures on staffing.

Mr McNaught noted that these high level activity figures fed through in January when work was progressed towards savings action planning – however, with one sixth of the financial year still to go, this had allowed for mitigation to be put in place.

Mr Crichton agreed that although the current situation was difficult, it was retrievable. At the same time, the Board should demonstrate learning from this especially in how to manage spikes in activity throughout the year. It was essential to recognise that good governance required a build up of reserves in order to better manage any future spike in activity.

Mr Johnston sought further clarity on the nature and timing of the spike in activity e.g. compared with the previous four months. Mr McNaught acknowledged that there had also been increased activity in August – September 2017 but this had been built into the projection based upon the position at the end of November 2017, when it had appeared to be the case that a break-even position would be achieved.

Mr Currie emphasised the importance of acknowledging all the factors that led to the Board being in this position, and that it was essential that learning should be taken to ensure a timely and appropriate management of this going forward.

In answer to a question from Mr Brackenridge about how the savings plan was being implemented and its efficacy, Mr Mc Naught provided assurance that savings were being sought from each part of the organisation and from every Budget Holder, albeit that nursing costs were of critical importance. Mr Crichton underlined the importance of the Board being provided with appropriate assurance that the management team had implemented and were taking forward all appropriate measures which would give confidence in projecting year end break-even position. There would be further discussion of this in today's private session of the Board. He also emphasised that this was being tightly monitored and that any perceived deviation from this projection would be reported to the Board.

Mrs Carmichael asked for further assurance in relation to workforce planning – was there a requirement to re-visit the strategic direction of the plan. She asked if there was a structural

problem within the Board which required longer term management. Mr Crichton reminded the Board of the strategic direction taken by the Board in terms of workforce planning. There was a focus on managing retirements so as to ensure that staffing did not fall below establishment level. Further, work was being progressed in relation to reducing levels of sickness absence to generate support for core staffing. This had been challenging to date and a position wherein there was resilience against the need for overtime had not yet been achieved. He assured the Board that the management team were sighted on the legal requirements for nursing workforce. Mr Richards added that in spring 2019, there would come into being a legal requirement for Health Boards to provide workforce planning tools for nursing – and action was being taken within TSH in readiness.

Further, reporting was expected from the Nursing Resource Utilisation Group in April 2018. A further update and advice would be brought to the Board in April 2018. Members also agreed that it would be helpful if a development session for Board members could be organised to place these developments in a national context.

Action – Mr McNaught/ Mr Crichton

Mr McNaught confirmed that the financial position to 31 March 2018, would be presented to the Board in April 2018. He also confirmed that Scottish Government had been made aware of the Board's current financial position.

Members noted the content of the report, and in particular that the position was being closely monitored on a weekly basis. If there were any developments that required to be referred back to the Board, this should be done without delay during the intervening period.

NOTED

10 LOCAL DELIVERY PLAN (LDP) PERFORMANCE REPORT TO 31 DECEMBER 2017

A report was submitted to the Board, from the Finance & Performance Management Director, which invited Members to note reported progress on performance management activities for the period to December 2017.

The report indicated that the Board had maintained good levels of performance in many areas as well as some areas were performance had fallen short and which therefore merited some further comment. The key KPIs on which it was anticipated that targets would not to be met continued to be patients' activity, patients' BMI and sickness absence.

Mr Brackenridge noted that it was disappointing to note the data on patient BMI, and asked for further assurance on the actions being taken in this regard. Professor Thomson referred to the array of actions which were being taken as part of the Healthy Choices project and confirmed that this was reported to the Clinical Governance Committee as appropriate.

Board Members requested that in future reporting, there should be further advisory column added to note that actions being taken to mitigate the position.

Action – Mr McNaught

NOTED

11 OVERSEAS TRAVEL REQUESTS

A paper was submitted to the Board, from the Chief Executive, which requested the Board's approval for overseas travel to the International Association of Forensic Mental Health Service Annual Conference. This request came from the Forensic Network and funding would come from the Forensic Network.

Professor Thomson advised the Board that this was a major international grouping to which The State Hospital belonged – the object of the conference would be to sharing of clinical practice and research.

Mr Currie requested clarification as to the funding mechanism and the appropriate approving body and mechanism for this. Mr Crichton advised that this was a matter of governance, with funding being received from Scottish Government and ring-fenced to the Forensic Network, although managed through TSH. It should be noted that those attending the conference would be attending on behalf of the Forensic Network rather than TSH. Mr McNaught added that although some staff members from The State Hospital had attended the conference in the past, as part of their development, it was not planned for any staff members to attend this year.

Professor Thomson highlighted that the Forensic Network Board would be required to approve this funding. Mr Crichton agreed that in terms of governance this item should more properly have been brought for noting following approval by the Forensic Network Board as the TSH Board also required to be sighted on any proposed overseas travel

There was discussion around the perception of funding being available for overseas travel, even though the monies involved were not part of the Board's budget. At the same time, it was also acknowledged that TSH should be involved in such events as part of continuation of its reputation for high quality care.

Mr Currie noted that there would be overall approval from this Board, with understanding that approval was not being sought or required and therefore this would be matter for noting. In view of this, there was a request from the Board for specific guidance on governance of the Forensic Network to clarify the appropriate body and mechanism for any future funding request.

Action – Mr Crichton

NOTED

12 MASONRY REVIEW REPORT

A paper [Paper No. 18/07] was submitted from the Security Director, which asked the Board to note that an independent investigation into masonry support and ties at The State Hospital had been carried concluded The report supplied had concluded that the buildings were in an acceptable condition for their age with minor cracking in some areas". Although minor issues were identified, these did not present concern at this time.

NOTED

13 AUDIT COMMITTEE – UPDATE

Mrs Carmichael provided Members with a verbal update on the last meeting of the Audit Committee, on 18 January 2018 as the Minutes were not yet available.

The Committee had received the annual update on Resilience Arrangements from the Security Director as well as an Attendance Management Update from the Interim Director for Human Resources.

The Director of Nursing and AHPs had provided a report on Effective Rostering & Overtime. The Finance and Performance Management Director had provided the Committee with an update on the Fraud Action Plan, as well as the Corporate Risk Register. The Internal Auditors had reported on the Complaints System as well as the Patients Funds – Mr Johnston requested a copy of the audit report on Complaints as part of his role as Chair of the Clinical Governance Committee.

Action – Ms Smith

NOTED

14 CHIEF EXECUTIVE'S REPORT

A paper [Paper No. 18/08] was submitted to the Board by the Chief Executive, which highlighted and provided an update to Members on issues that did not feature elsewhere on the Board's formal agenda.

This included an update on the further progress made during January and February 2018, on the National Boards Delivery Plan. A development session had taken place on 7 February 2018 and had included discussion on digital transformation as well as planning for a sustainable workforce. Mr Currie noted the work of the Chief Executive in engaging in this process for TSH, and that further updates would be brought back to the Board in this regard.

Mr Crichton provided an update to Board Members on the sustained pressure on nursing workforce availability and on the budget due to additional hours being worked with clinical activity having peaked during January 2018. Work was continuing to refresh the nursing workforce plan. Extraordinary Senior Management Team and Joint Staff Side meetings were held on 7 February 2018 as engagement on a range of additional measures to address these pressures.

The Annual Meeting with the Mental Welfare Commission took place at The State Hospital on 1 February 2018, and this had been an opportunity to share information on key issues both locally and nationally.

Mr Crichton updated Board Members of the Corporate Parenting Plan for The State Hospital which set out how the Board will deliver its statutory obligations as Corporate Parent under the Children and Young People (Scotland) Act 2014.

In relation to patient safety, Mr Crichton emphasised the work of the Scottish Patient Safety Programme (SPSP) group in relation to the successful roll out of DACA – a structured professional judgment tool which would support decision-making to support patients on a day to day basis through e.g. enhanced clinical observation.

In response to the update on overall hand hygiene compliance, Mrs Whitehead requested clarification on variance across wards, and Mr Richards agreed to review and provide clarification on the data.

Action – Mr Richards

NOTED

15 ANY OTHER BUSINESS

Mr Currie wished to record recognition and appreciation of the Board on the huge dedication on the part of the staff of The State Hospital in working together to address the pressures experienced at the current time.

NOTED

16 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 26 April 2018 at 9.45am in the Boardroom, The

State Hospital, Carstairs.

NOTED

17 EXCLUSION OF PUBLIC AND PRESS

Members approved a motion to exclude the public and press during consideration of the items listed at Part II of the agenda in view of the confidential nature of the business to be transacted.

AGREED

The meeting concluded at 11.45pm

ADOPTED BY THE BOARD

CHAIR _____
(Signed Mr Terry Currie)

DATE 26 April 2018

MINUTE ACTION POINTS
THE STATE HOSPITALS BOARD FOR SCOTLAND

ACTION NO	AGENDA ITEM NO	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	6	Request for Section 22 Approval	Medical Director to arrange for Dr Villiers to be formally placed on TSH list of Approved Medical Practitioners.	Lindsay Thomson	Immediate	**Completed**
2	7	Patient Learning – Annual Report	Board Secretary to note and ensure that Non-Executives received invitations to the annual Awards Ceremony.	Margaret Smith	Immediate	**Completed**
3	7	Patient Learning – Annual Report	To include further detail in the annual report for the Board regarding: • Figures for core skills screening in numbers rather than percentages • Further detail for non-attendance at learning sessions due to patient mental/physical condition. • Separate the figures for Iona 2 patients (and other patients with intellectual disabilities) to give more clarity in rates of core learning skills.	Sandra Dunlop	Immediate	Action taken at local level to ensure required level of reporting for next report to the Board – **Completed.**

4	7	Patient Learning – Annual Report	To keep the Board infirmed on progress towards recruitment of gardener.	Mark Richards	Ongoing	Ongoing – June Agenda
5	7	Patient Learning – Annual Report	To keep the Board updated regarding the IT upgrade.	Robin McNaught	June Agenda	Upgrade in April and update to be brought to Board – June Agenda
6	9	Finance Report as at January 2018	To provide an update to the Board in respect of the Nursing Resource Utilisation Group, followed by a development session for Board Members to place these developments in national context.	Robin McNaught/Jim Crichton	April Agenda/ 31 May 2018 confirmed date	April Agenda/ 31 May 2018 confirmed date
7	10	Local Delivery Plan (LDP) performance report to 31 December 2017	For future reporting, add an advisory column to note actions being taken to mitigate the position.	Robin McNaught	Immediate	Action taken at local level to ensure required level of reporting for next report to the Board – **Completed.**

8	11	Overseas Travel Requests	Guidance for the Board on the governance of the Forensic Network in respect of the appropriate body and mechanism for any future funding request.	Jim Crichton	June 2018	June Agenda
9	13	Audit Committee – Update	Mr Johnston required a copy of the internal audit report in respect of complaints.	Margaret Smith	Immediate	**Completed**
10	14	Chief Executive's Report	Hand hygiene compliance rates – an update on the variance between wards.	Mark Richards	April 2018	A verbal update to be provided to the Board in April.

Board Paper 18/13

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 April 2018
Agenda Reference:	Item No: 7
Sponsoring Director:	Director of Nursing/AHP
Author(s):	Director of Nursing/AHP and Head of Planning and Business Support
Title of Report:	Planning for Long Term Service Sustainability
Purpose of Report:	For discussion

1 SITUATION

This paper sets out a proposal to take forward a programme of work that will identify actions required in 18/19 to achieve service delivery that is financially sustainable, and to realise our strategic ambitions as a Board.

This is set in the context of a risk of year end overspend identified in late January 2018, and learning gleaned from the need to design and deliver a recovery plan during February and March 2018. Furthermore, there are emerging pressures relating to the 18/19 budget as a consequence of overall requirements for financial efficiency, and delivery of our share of the National Board's savings target of £15,000,000.

2 BACKGROUND

The State Hospital has recently implemented a financial recovery plan to ensure control over spend and to reach a year-end financial position of near balance, whilst delivering safe, effective and person centred care.

This 'critical' recovery period has ended, with successful outcomes related to mitigating against pressure on the year-end financial position. Quality of care was maintained, although it is recognized that the more restrictive approach to practice was not an ideal nor sustainable situation for delivery of high quality care that meets the principles of the Act. Other actions, such as the suspension of training could not be sustained beyond the end of the financial year.

At the SMT held on 14 March SMT, the savings plan measures were reviewed and adjusted, as set out in the final summary report on savings plan activity SBAR which has also been presented to the April SMT.

There is now a need to plan for a more sustainable approach to deliver clinical services across the hospital. This sustainability plan is a large scale transformation change programme for the hospital. It requires all senior leaders to support the development of a 'new model' of delivery of care and workforce transformation.

Action is required urgently to plan, implement, and embed transformation. This will require senior leader agreement, development of a multi-professional task group, development of terms of reference, with engagement and partnership working as key underpinning principles.

There are two distinct, but interrelated emergent themes for transformation change – these are workforce and model of care delivery.

There is a tight timescale to develop this, with an ambition to report on substantial progress to the Board development session planned for 31 May 2018, and to afford the Board the opportunity to consider the strategic implications of the emergent proposals.

Agreement on the governance and any financial implications for taking change programme forward will need to be reviewed.

3 ASSESSMENT

There are clear risks of maintaining the status quo in terms of current approach to service delivery and workforce deployment. The primary risks are:

- Financial unsustainability and associated consequences
- Service delivery model that is mismatched to patients needs
- Workforce model that is not best matched to service or care need
- Failing to achieve the strategic aims of the Board
- Reputational risk for the Board.

In considering our approach to change, we need to mobilise the hospital towards a vision of a fundamentally different future state by means of:

- Identifying key themes that can make a big difference in terms of leverage
- A shift in power and more distributed leadership
- Comprehensive and active engagement of stakeholders
- Identification and articulation of benefit in terms of care quality
- Ensuring time, resources, and focus in achieving sustainable change
- Mutually reinforcing of changes in multiple systems and processes.

Designing transformational change in The State Hospital

In planning for a programme of change, it is important that the need for change is identified. Given our experiences over 17/18 in terms of our clinical service delivery model, workforce, and financial sustainability, it is clear that the status quo is not a viable option as it will likely deliver the same outcomes.

The recent development and delivery of the financial recovery plan has supported framing and reframing the current issues. This demonstrated that high impact change can be delivered, for example, we changed our care delivery approach for our patients with the highest support needs, through focusing staffing and high quality engagement during the 9-5 period as opposed to full shifts.

Looking at models for change, such as that promoted by the Sustainable Improvement Team in NHS England, and also referring to IHI promoted improvement processes, the suggested approach to achieving transformational change could be split into 3 phases.

Timeframes need careful consideration by SMT in terms of what is realistic and achievable, balanced with a need to move rapidly towards service sustainability. There are already pressures building in 18/19 related to care delivery and associated staffing costs.

It is proposed that a multi professional task group will be established to take this work forward, reporting to the SMT. This group will be led by the Director of Nursing and AHPs, supported by the Head of Planning and Business Support, and will meet weekly.

Phase 1. Planning

We need to build the will across all staff groups involved, and identify the need for change. In developing a vision for a 'new reality' the 3 horizons model can help with this.

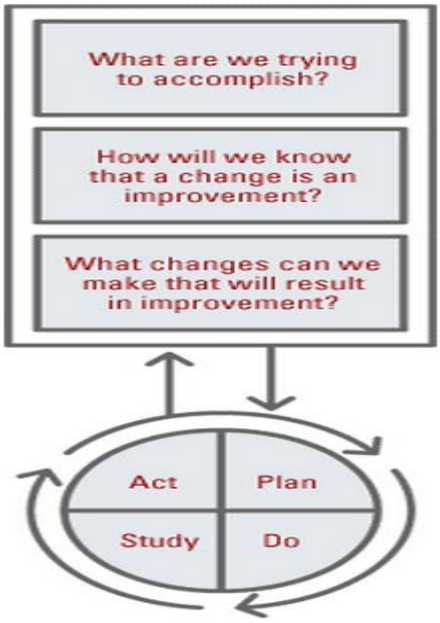
There is an opportunity with the recent delivery of the financial recovery plan to emphasise the case for change (horizon 1), to use this as a catalyst to describe our ideal sustainable future state (horizon 3) and to work through transition towards sustainability (horizon 2).

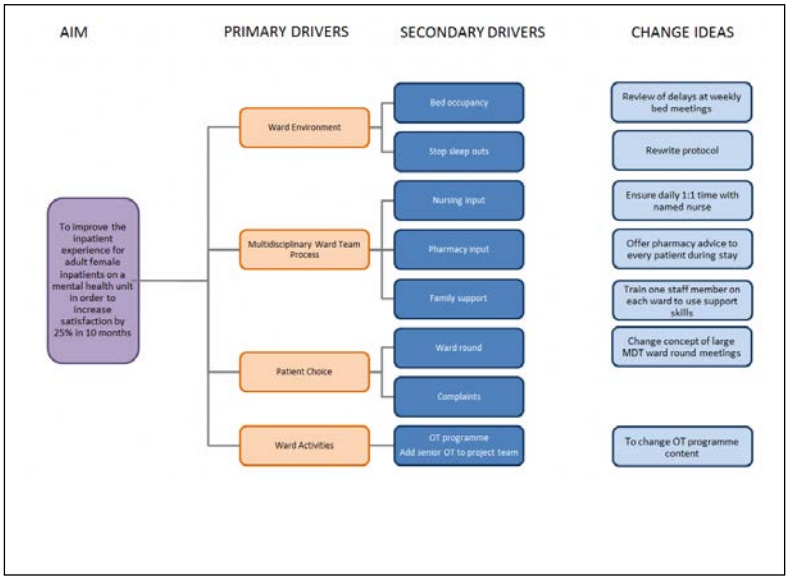
We have well established systems of stakeholder engagement which we have used for strategy development and to inform, for example, workforce change. A blend of face to face engagement and seeking written feedback should be used. Patient and carer involvement will be part of the engagement processes, drawing on Scottish Heath Council Guidance.

Service improvement processes will be an important part of our approach to this, in modelling the outcomes expected, using the model for improvement to detail what the change will be, and how we will measure this.

We have examples of where this has worked well in achieving change, such as the Patient Active Day work in Iona 2. We also have an increasing cohort of service improvement practitioner who are trained to a high level in improvement methodology.

Developing driver diagrams for the 2 distinct change themes (service delivery model and workforce) and engage our workforce in the development of these will be important. The driver diagram below is simply an example of where this has been used in other services to help map out change:





A 'Leadership Pause' to ensure clarity of vision and buy in of all relevant leaders is proposed as part of our model and process of change. We need to check we are ready, that we agree with the vision, that have we engaged, and that we have built the necessary will for change across our stakeholder groups. The SMT can fulfil this role on a monthly basis.

It is anticipated that changes identified will need to be grouped into short, medium and longer term change and that we will need to assess the impact of each so as to inform our change priorities.

This phase of work will be completed in advance of the Board development session scheduled for 31st May 2018, with this session being part of this 'pause'.

Phase 2. Implementation

Having identified change priorities, the next stage is to carry out tests of change, review regularly adjust and retest cycles. This approach needs to be flexible and dynamic, and will be underpinned by weekly review meetings.

While the approach in this paper is described as 3 distinct phases, in reality a more blended approach will be required. For example, the implementation of some actions may well be taken forward in advance of the full completion of the planning phase where there is data available to support implementation of change.

Data for improvement will be qualitative and quantitative. Agreement for measurement of change and how these will be gathered and reviewed will be delivered by the task group, and written into the driver diagram project outcomes**.** There is also data that can be referred to from the series of review meetings held during this period, and from subsequent SMT discussions.

The identification of quick wins and high impact changes will be necessary, building on what we have learned from the delivery and review of the financial recovery plan.

Communication across the site will be critical in ensuring ongoing engagement and ownership by stakeholders.

There are existing change opportunities which can be aligned with this programme of work, for example the Nursing Resource Utilisation project, preparation for safe and effective staffing legislation, and the improving observation practice work-stream through SPSP.

It is proposed that a leadership guiding coalition could link regularly with the task group to ensure alignment, connection and discuss dilemmas. There may be an opportunity for the Clinical Forum to fulfil this role.

Phase 3. Review, summarise and disseminate

In this phase, the ambition is to scale and spread any tests of change. Any changes should be written into local delivery plans and strategic plans where appropriate. Communication across the site and ensuring ongoing engagement and ownership by stakeholders will be important.

Our future state should ensure the following:

- Financial sustainability for 18/19 and beyond
- Service delivery model that is clearly matched to our strategic ambitions – tackling inequality, and efficient and effective resource utilisation
- Workforce sustainability, matched to service – size, shape, deployment (shift patterns), including a refresh of the workforce plan.
- Form of service delivery clearly following the function of the hospital.

In delivering this programme of work, we need to create a new vision that is better and fundamentally different from the status quo, and in doing so, identify and communicate key themes that people can relate to and that will make a big difference.

We have an opportunity on the back of the financial recovery plan to reflect back on what was achieved through different ways of working.

A multitude of different activities will be needed to realise the transformation required, and we need to frame issues in ways that engage and mobilise the imagination, energy and will of diverse stakeholders i.e. distributed leadership. Many people can contribute to the leadership of change and there is an opportunity in this work for positive culture change through the co-creation and co-delivery of this work. A strong focus on partnership working will underpin this programme of work.

We will need to mutually reinforce change across multiple processes, and through emergent planning and design based on monitoring of progress and adapting of actions through PDSA cycles. We may need to transform mindsets, at all levels, to achieve inherently sustainable change.

Group membership will be the responsibility of the task group lead, but will need strong clinical leadership and operational management presence, partnership involvement, improvement expertise, involvement and equality input and administrative support.

The creation of a task group was agreed at SMT on Wednesday 18 April 2018.

4 RECOMMENDATION

The Board is invited to agree to the following recommendations:

- To **note** this planned work-stream, and to **note** that the SMT has endorsed the creation of a task group to take forward this work. A report on progress will be delivered to the Board at the Development Session scheduled for 31 May 2018.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports delivery of service strategy
Workforce Implications	Considered in Section 3 of the report
Financial Implications	Significant financial implications if this work is not progressed
Route To SMT Which groups were involved in contributing to the paper and recommendations.	Via CEBM
Risk Assessment (Outline any significant risks and associated mitigation)	Significant risks in not progressing this work. Risks associated with timescales for delivery.
Assessment of Impact on Stakeholder Experience	Not formally assessed
Equality Impact Assessment	Not formally assessed.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 April 2018
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Director of Nursing and AHPs
Title of Report:	Update on part 4 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.
Purpose of report:	To update Board on progress against legal duty.

1 SITUATION

On 19th March 2018, the Augmentative and Assisted Communication aspects of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (part 4) came into force.

Part 4 comprises section 33 of the Act, which inserts a new section into the National Health Service (Scotland) Act 1978 which confers a new legislative duty on the Scottish Ministers. This is to provide or secure the provision of communication equipment and support in using that equipment to such an extent as they consider necessary, to meet all reasonable requirements, to any person who has lost their voice or has difficulty speaking.

2 BACKGROUND

On 19 March 2018, the duty became exercisable by Health Boards and one Special Health Board – the State Hospitals Board for Scotland.

The Scottish Government's Assisted Communication Team have been working with partners, including NHS Boards and nominated Executive Leads for Augmentative and Alternative Communication (AAC) in each NHS Board area across Scotland, to ensure readiness for commencement, and will continue to work with partners to support the delivery of the requirements of this legislation.

Locally, there has been regular liaison with the Scottish Government AAC team as we have prepared for this duty.

3 ASSESSMENT

The AAC lead is the Director of Nursing and AHPs, supported by the Lead AHP/Lead OT. Preparatory work has been completed to ensure that communication needs are assessed at the pre admission stage, with changes made to the pre admission assessment paperwork.

Access to Speech and Language Therapy (SALT) is an important part of meeting our duty under the Act. We have an interim arrangement in place with NHS Lanarkshire to access support on an as required basis, including links to their AAC Lead. Agreement was reached with NHS Greater Glasgow and Clyde to provide SALT on a service level agreement basis, however, the preferred post holder in NHS Greater and Glasgow and Clyde has recently declined this. An advert for a SALT has now been raised.

A local pathway has been developed which sets out the steps in meeting AAC needs, from recognition of potential need through to going forward with AAC support. This is detailed at appendix 1 of this paper.

There is currently one patient in the State Hospital who has an assessed need related to AAC, and has an iPad to support meeting their communication needs.

Going forward, we await the development of national guidance on the definitions of communication equipment and support in using that equipment. This should be available by May 2018. It is anticipated that this guidance will include a vision statement, principles, and definitions of equipment and support in using that equipment. The guidance will seek to assist the successful implementation of the duties and the continuous improvement of the delivery of care, support and services for people who use and need AAC.

4 RECOMMENDATION

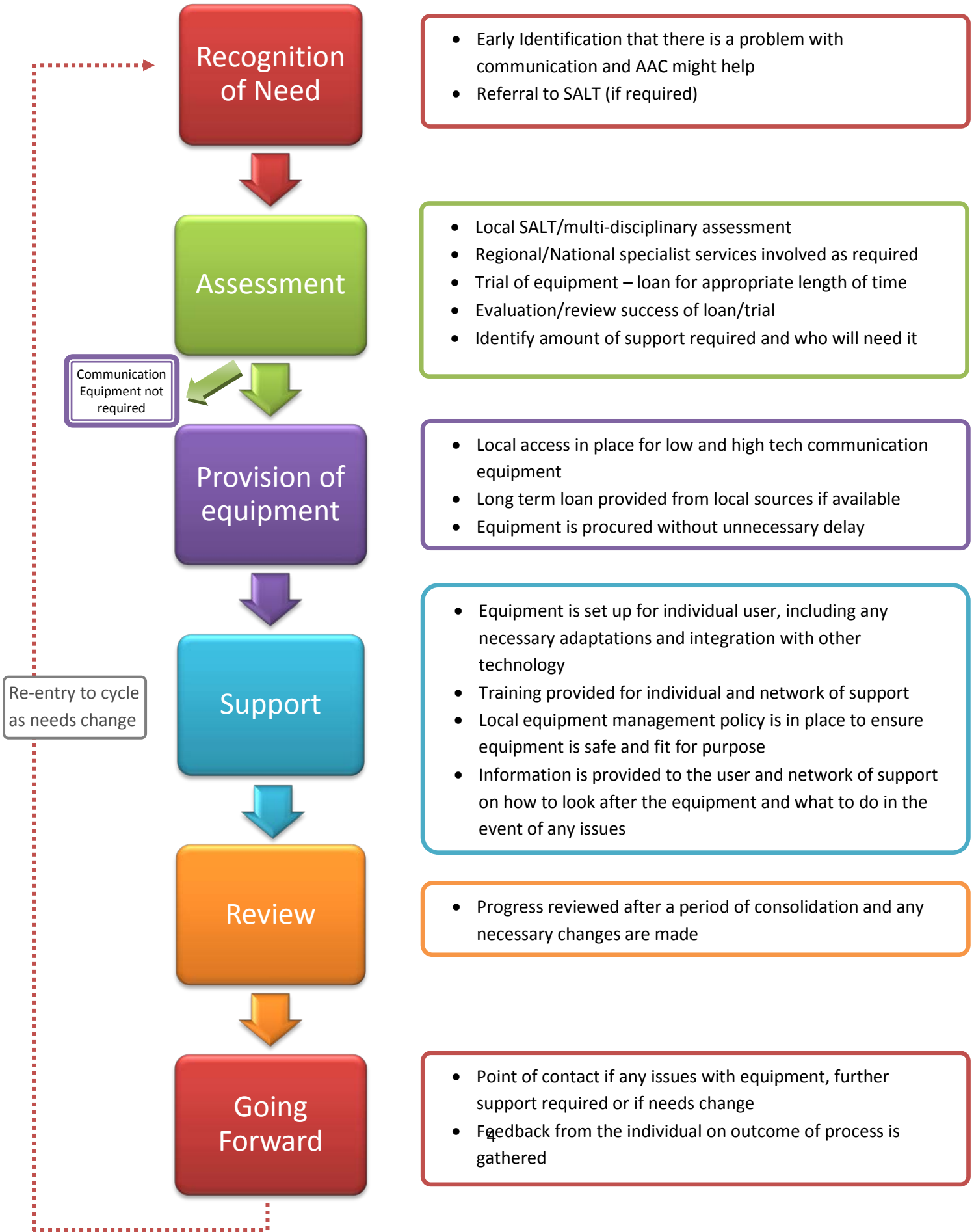
The Board is invited to agree the following recommendation:

- To **note** progress against our duty as it relates to part 4 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Supports meeting statutory duty under the Act, and also supports strategic priority of tackling inequality.
Workforce Implications	Considered in Section 3 of the report
Financial Implications	No significant financial implications identified
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Via SMT
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	Improves stakeholder experience for those with identified AAC needs
Equality Impact Assessment	Not formally EQIA Screened

Appendix 1


Recognition of Need
Early Identification that there is a problem with communication and AAC might help
Referral to SALT (if required)
Assessment
Local SALT/multi-disciplinary assessment
Regional/National specialist services involved as required
Trial of equipment – loan for appropriate length of time
Evaluation/review success of loan/trial
Identify amount of support required and who will need it
Communication Equipment not required
Provision of equipment
Local access in place for low and high tech communication equipment
Long term loan provided from local sources if available
Equipment is procured without unnecessary delay
Support
Equipment is set up for individual user, including any necessary adaptations and integration with other technology
Training provided for individual and network of support
Local equipment management policy is in place to ensure equipment is safe and fit for purpose
Information is provided to the user and network of support on how to look after the equipment and what to do in the event of any issues
Re-entry to cycle as needs change
Review
Progress reviewed after a period of consolidation and any necessary changes are made
Going Forward
Point of contact if any issues with equipment, further support required or if needs change
Feedback from the individual on outcome of process is gathered

Board Paper 18/15

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26th April 2018
Agenda Reference:	Item No: 9
Sponsoring Director:	Professor Lindsay Thomson
Author(s):	Professor Lindsay Thomson and Monica Merson
Title of Report:	Implementation of the Duty of Candour in The State Hospital
Purpose of Report:	Update on progress

1 SITUATION

The duty of candour provisions in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill were given Royal Assent on 6 April 2016. The implementation date for the duty of candour provisions was 1 April 2018. Principles of candour exist in many organisations and within professional codes of conduct. The Act introduces a statutory organisational duty of candour on health, care and social work services

The overall purpose of the duty is to ensure that organisations are open, honest and supportive when there is an **unexpected or unintended incident resulting in harm or death**, as defined by the Act.

Incident which activates the duty:
The duty of candour procedure must be carried out as soon as practicable after becoming aware that an individual who has received a health, social care or social work service has been the subject of an unintended or unexpected incident, and in the reasonable opinion of a registered health professional has resulted in or could result in:

- death of the person
- a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions
- an increase in the person's treatment
- changes to the structure of the person's body
- the shortening of the life expectancy of the person
- an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days
    - the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days
- the person requiring treatment by a registered health professional in order to prevent – the death of the person, or (ii) any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above

The State Hospital has responsibility for:

- carrying out the procedure

- undertaking any training required by regulations
- providing training, supervision and support to any person carrying out any part of the procedure as required by regulations
- reporting annually on the duty - this will include the number of incidents, how the organisation has implemented the duty and what learning and improvements have been put in place

2 BACKGROUND

Planning for the implementation of the duty is now established in The State Hospital. The duty of candour has been considered at Senior Management Team meetings, Clinical Governance meetings and has featured in awareness raising updates for all staff. Scottish Government issued guidance for the implementation of the duty of candour in March. Scottish Government have acknowledged that 2018/19 will be viewed as a transition year as organisations develop and test their process for implementation and reporting.

In preparation for the legislation an initial exploration of previous incidents that could have triggered the duty of candour were reviewed in November 2017. At this point is was estimated that there could be as many as 350 duty of candour events, however on refection and matching the incidents against the guidance on significant harm, this figure will be substantially lower. The incidents that duty of candour may apply to have been identified as coming through DATIX reports; SUIs and CIRs; complaints; claims; ASP cases; RIDDORs and delayed discharges.

3 ASSESSMENT

An implementation core group for the Duty of Candour procedure was established in March to provide leadership oversight and a focus for duty of candour activity. Appendix 1 outlines the action plan for this group. A driver diagram was developed to outline the key elements of implementation for the duty of candour. The core group have agreed to meet monthly with weekly updates on any potential duty of candour incidents. The group will monitor activity relevant to the procedure and report regularly to SMT. The group will also ensure that any duty of candour incidents are investigated in line with Scottish Government guidance and timescales. An annual report on the duty of candour incidents will be produced and submitted to Scottish Government.

Ensuring that staff are aware of the duty and their responsibilities around the procedure has been a focus over the last month with various activities taking place. This has included a journal club presentation, bulletins circulated to all staff and an e learning resource being adopted onto the learn pro platform and flagged as mandatory for all clinical staff. A reporting process for the identification of duty of candour incidents has been developed on the Datix system.

The focus on implementation will continue over the next period. The core group will provide a regular forum to ensure that priority actions are taken forward to ensure effective implementation of the duty of candour procedure, this will include.

- Training for staff carrying out investigations
- Awareness raising for specific groups of staff
- Mapping out of process for decision making and investigation of incidents to implement the procedure
- Review and development of policies to ensure clarity of process for recording, reporting, investigation and alignment of the procedure with current adverse events reporting and monitoring policies.

- Learning from any incidents is reported back to SMT, Clinical Governance Committee and The Board, and be embedded in organisational change and clinical management as appropriate.

4 RECOMMENDATION

The Board is invited to note the progress made on preparation of the implementation of the duty of candour and endorse the actions that are required to ensure that The State Hospital is compliant with the duty of candour procedure.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	It is a legislative requirement for the hospital
Workforce Implications	All clinical staff need to be aware of the procedure and some staff will require specialist training in investigation and reporting
Financial Implications	No financial implications if approved
Risk Assessment (Outline any significant risks and associated mitigation)	Risk to reputation if we are not compliant with legislation
Assessment of Impact on Stakeholder Experience	The implementation of the duty of candour procedure will enhance stakeholder relationship though a transparent and honest approach to apology and investigation is serious harm occurs as a result of care
Equality Impact Assessment	The procedure requires that consideration is taken of the needs of individuals in relation to receiving information and acceptability of different methods of communication to meet individuals needs if harm has occurred

Board Paper 18/15

Duty of Candour Implementation Action Plan **Appendix 1**

Following the establishment of the Duty of Candour Core Group in March 2018, the group agreed actions to move forward the implementation. The table below provides an overview of the actions and also highlights next steps for activity.

Update of actions for the Core Group

Area of activity	Action taken by 17th April 2018	Next steps and timescale	Lead
Process			
Establish a DOC core group to support implementation and reporting	Group has met twice in March. Group membership is D Alcock – (chair), N Watt, K Blessing, M Merson, CMcQ. Agreed to expand the group to include Psychology and ensure nursing representation in attendance Group to meet monthly Group to receive e-mail update on DOC cases weekly Next Group meeting planned for Monday 7th May 3.30 Management Centre	DA to invite new group members for meeting in May NW to set meetings and update group weekly on any DOC incidents	DA NW
Review our SUIs and CIRs to determine frequency of disclosure to patients naturally occurring – understand our baseline	No progress made on detailed analysis of CIR's and SUI's	Need to take forward urgently and report to May meeting	NW and Core group
Develop and test our recording process on Datix	NW developed Datix recording process by the end of March NW to establish a DOC e-mail box to alert the team to potential DOC incidents	Review process and make any improvements required – discuss in May	NW
Determine our procedure – process map	Draft V1 process map developed – MM and KB, needs further refinement and align with Scottish Government guidance	Process map to be matched against the SG guidance and discussed with group in May	MM
People	Action taken by 17th April 2018	Next steps and timescale	
Enhanced skills - Develop local training for those likely to be involved in investigations and	Still to be developed MM attending NHS Lothian's simulation training in mid April to identify if this is a potential area for development for TSH		

reviews	Potential for root cause analysis training to be provided for core group and others who may investigate – NW to take forward	Need to reach agreement on the appropriate training for core group and others who may investigate DOC incidents and plan for implementaion at May meeting	NW
Awareness raising - Embed as mandatory training an e- learning module developed by NES on learn pro for clinical staff	e-learning module now embedded on Learn pro	MM to check the uptake of this with S Dunlop and report to core group in May	MM
Awareness raising – provide general awareness sessions or information for all relevant staff .	Session at journal club on 26th March Staff Bulletin developed and distributed in March	Consider how to reach other staff groups e.g. nursing staff	LT/ MM
Governance	Action taken by 17th April 2018	Next steps and timescale	
Publish any supporting documents and guidance/regulations from Scottish Government on the intranet	Guidance shared with Core Group	Published guidance – MM to speak to CMc to take forward. Guidance shared with core group	MM
Provide update paper to the April Board meeting	Board paper prepared for April meeting		LT/ MM
Report to clinical governance and audit committee	Paper to be prepared– next CGC 10TH May		DA
Develop and align policies and procedures to ensure clarity of process	Action to follow	Paper to be developed and discussed with core group in May	NW/ MM
Produce annual report	Annual report template	Annual report template to be developed and agreed with core group	NW/ MM
Culture	Action taken by 17th April 2018	Next steps and timescale	
Ensure learning from incidents is feedback to organisation and where required changes and informs practice	Feedback from baseline questionnaire to be analysed	Report to core group in May	MM

Staff involved are supported	Action to follow	For discussion with wider group	

THE STATE HOSPITALS BOARD FOR SCOTLAND
CG(M) 18/01

Minutes of the Clinical Governance Committee Meeting held on Thursday 22 February 2018 at 9.45am in the boardroom, The State Hospital, Carstairs.

CHAIR:	
Non Executive Director	Nicholas Johnston
PRESENT:	
Non Executive Director	Elizabeth Carmichael
Non Executive Director	Maire Whitehead
IN ATTENDANCE:	
Chief Executive	Jim Crichton
Chairperson	Terry Currie
Chair of Medical Advisory Committee	Khuram Khan
Interim Head of Psychological Services	Gary Macpherson
Finance & Performance Management Director	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Director of Nursing and AHP	Mark Richards
Board Secretary	Margaret Smith
Clinical Effectiveness Team Leader	Sheila Smith
Medical Director	Lindsay Thomson
Lead AHP	Catherine Totten [Item 12]

1 APOLOGIES AND INTRODUCTORY REMARKS

Mr Johnston welcomed everyone to the meeting. In particular, he welcomed Ms Merson who had recently come into post as Head of Corporate Planning and Business Support. There were no apologies to be noted.

NOTED

2 CONFLICTS OF INTEREST

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

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 9 November 2017 were approved as an accurate record subject to the following amendments:

Item 6 - *"There is a gap in staffing in the Skye Centre. Posts are being recruited to the Skye Centre".*
Item 7 - *"These medications are no longer on the national contract and will need to be sourced from other companies at an increased cost".*
Item 9 – *"Members were concerned about the seriousness of the incident and asked for assurances about learning and prevention of reoccurrence".*

NOTED

4 PROGRESS ON ACTION NOTES

- ***Duty of Candour***

A paper was submitted to update Members on progress made in readiness for implementation of the legislation on 1 April 2018. It was noted that the national guidelines had not been published to date, and assurance was provided that The State Hospital would produce a policy and procedure in line with national guidelines.

Professor Thomson emphasised that it was good practice on the part of clinicians to be open and to apologise should that be appropriate. However, the legislation placed a statutory obligation on the individual clinician to do so.

It was agreed that a further update should be brought to the next meeting of this Committee.

Action: L Thomson/M Merson

- ***CIRs***

Mr Richards provided an update in respect confirming that:

- Newly registered nursing staff receive induction training on administration of medication.
- There had been agreement on key allocation within wards areas.
- A new system had been brought into being to highlight multi-dose medications – a manual system of labelling medicine cabinets with reminders was now in place.

NOTED

5 MATTERS ARISING

There were no further matters arising.

NOTED

6 PSYCHOLOGICAL THERAPIES SERVICE REPORT

A paper was submitted to the Committee by the Interim Head of Psychological Services (Dr McPherson) who was present to provide an overview for Members. He highlighted that the report was centred on the six quality dimensions from The Healthcare Quality Strategy for NHS Scotland.

In particular, safe care was demonstrated through 96% of patient risk assessment evidence documents being discussed at the annual CPA. The high level of engagement and completion of psychological therapies showed the effective nature of the care delivered. Over 2017, 93% of patients engaged in psychological interventions which compared with 85% for the same period last year and this evidenced the equitable nature of the care delivered.

Dr McPherson outlined some of the service developments during 2017 including development of the Connections programme, Safety and Stabilisation training and sharing of practice with the Forensic Matrix Implementation Group. He also highlighted some of the challenges and opportunities for the service over the coming year including making links with UK Special Hospitals for benchmarking, the Psychological Therapies Workforce Review and sequencing of therapies in collaboration with the iHub Quality Improvement Team.

Mr Johnston thanked Dr McPherson for his comprehensive report and for his briefing to the

Committee. Mr Richards agreed that this was a well-constructed report showing the efficient and effective use of resources. It was noted that the case review attendance target figure for Clinical Psychologists (page 12) should be 80% and that Dr Macpherson would amend.

Action – G Macpherson

Mr Currie asked for clarification around resourcing for the Healthy Living Group to rum on each Hub – the report indicated that difficulty had been experienced in doing so as each group required dialecticians and sports facilitators. Mr Richards explained that there had been difficulty in recruitment and retention of staff in these areas although there has been greater capacity recently. Dr Macpherson agreed the possibility of arranging groups on alternate Hubs and it was clarified that patients could attend from other Hubs so that this service could be more widely available.

Mrs Carmichael referred to the data on annual activity levels and asked if the decrease in patient numbers within the hospital had impacted on the number and variety of sessions offered to patients. Dr Macpherson advised that although there had been a smaller number of patient interventions, the nature of the patient cohort was such that more intensive input was being delivered, and the service was reaching all those who required interventions. Mrs Carmichael asked if consideration could be given to presenting the data in an alternative format to reflect this and Dr Macpherson agreed to present the data in percentage rather than number terms, going forward.

Actions – G Macpherson

Mrs Carmichael also asked how the impact of psychological therapies was measured in terms of the overall impact within the hospital i.e. rather than broken down to individual impacts. Dr Macpherson agreed that this could be a difficult to fix in concrete terms and noted that patients had self reported the benefit they perceived as having gained. Professor Thomson added that measuring impact was problematic with a small hospital population meaning that providing evidence of improvement was difficult. This was an area in which benefited from wider studies on a national basis. Dr Macpherson confirmed that further consideration would be given to how to measure overall impact in year on year terms to demonstrate continuing progress.

Action – G Macpherson

Mrs Whitehead asked about assessment of patients on admission and how this was used as a base to measure improvement. Dr Macpherson provided an outline of care planning for the first eight to ten weeks following admission, including assessment and monitoring. This would be different in each individual case, depending on the information received at the point of admission. This period was also used as a stabilising period for the patient's mental health before the clinical psychologist could engage fully with him.

Mr Crichton thanked Dr Macpherson for his report and advice to the Committee, and for all of his work over the course of the past eight weeks in fulfilling the role of Interim Head of Psychological Services. In particular, the completion rates of programmes was very reassuring.

NOTED

7 CLINICAL GOVERNANCE GROUP REPORT

A paper was submitted to the Committee on behalf of the Medical Director, to give assurance on delivery of the following strategic aims of the Board:

- Delivery of safe, effective and person-centred care based on available evidence and best practice.
- Achievement of demonstrable improvements in outcomes including the patient experience.

The report provided a summary of the work of the Clinical Governance Group over the past 12 months, and the Committee was asked to note the content of the report and to discuss any

improvements that should be made to it, going forward. Professor Thomson underlined that as many reports came to Committee throughout the year and had been given appropriate consideration, thought had been given to highlighting those areas that the Committee had not necessarily had specific reporting on. She highlighted the work of the Mental Health Practice Steering Group, and suggested that it be considered that a stand alone report should be brought to this Committee on a yearly basis.

Professor Thomson led Members through the report underlining CPA Audit results, the Clinical Quality Strategy, Evaluation of Independent Prescribing as well as multidisciplinary working with social work teams. She brought Members' attention to the reinstatement of the Hub Leadership Team (with the policy currently out to consultation as well as the impact of the DASA Inpatient Version risk assessment tool. She also highlighted progress on supporting the Healthy Choices Group and the implementation of Duty of Candour Legislation. Professor Thomson provided an overview of areas of good practice as well as future areas of work and potential service developments.

Mrs Whitehead raised concern at the lack of progress with new patients in terms of waiting times for physical activity assessment. Mr Richards clarified that were some inconsistencies in terms of the access to assessment in the Skye centre. Ms Smith confirmed that the data may be more usefully presented with the median rather than the mean, and that she would do so.

Action – S Smith

Mr Richards also advised that work was underway to revise pathways and it was expected that this would bring improvement in waiting times. It should also be remembered that upon admissions, some patients were too unwell to able to have this type of assessment carried out.

Mrs Carmichael praised the report which gave reassurance – however, she asked why there was no update in respect of the Clinical Observations Policy. Mr Richards advised that this was an ongoing workstream as part of improving clinical practice and patient safety.

In response to a question from Mr Currie, in respect of the reinstatement of Revised Hub Management Team, Mr Crichton confirmed that Hub Management Teams had been part of new modelling for leadership in the hospital but that these had not been implemented. There was renewed focus on progressing this with reporting to the Senior Management Team. Mr Richards added that although there had always been leadership groups in Hubs, these had been progressed under different names and forums and that this had led to recognition of the need for clarity and focus between clinical and operational leadership with the Hub Leadership Team now in place to focus this. This was a multidisciplinary group which met both weekly and monthly, with the intention of standardising practice across Hubs.

With reference to feedback on the presentation of the report, Mr Johnston asked Members to consider whether it was necessary for the report to contain reminders on reports that had already been presented and considered by the Committee throughout the year. He asked for more focus on what difference the Clinical Governance Group had made to the organisation over this period especially in terms of taking an integrated approach. He asked for reporting on clinical outcomes to come to the Committee on a quarterly basis, and agreed that the Mental Health Practice Steering Group should report to the Committee on a stand alone basis. These points were agreed as actions going forward, and it was noted that the Mental Health Practice Steering Group would report into the Clinical Governance Group first, and from there into this Committee.

Actions- L Thomson

NOTED

8 MEDIUM AND HIGH SECURE CARE STANDARDS ACTION PLAN

A report was submitted to the Committee on behalf of the Medical Director which provided an annual update from the Medium and High Secure Care Standards action plan. This had followed the peer review visit which had taken place in October 2013, to assess The State Hospital (TSH) against the standards. It was confirmed that following approval of the Suicide Awareness and Prevention Policy at Senior Management Team, the action plan had been completed.

NOTED

9 MEDIUM AND HIGH SECURE CARE STANDARDS SELF ASSESSMENT 2018

A report was submitted to the Committee for their information in respect of the peer review visit due to place at TSH on 27 April 2018 by the Forensic Network as well the work ongoing in preparation for this by the Clinical effectiveness department. Members were content to note progress in this regard and oversight by the Clinical Governance Group. It was noted that, a further report would come to this Committee once the process had been completed.

Action – L Thomson

NOTED

10 LEARNING FROM FEEDBACK

A report was submitted to the Committee on behalf of the Medical Director, which provided Members with an overview of activity for complaints and feedback in the third quarter of 2017/18. Professor Thomson led the committee through the report, highlighting the impact of the new complaints policy and procedure which followed national guidelines from the Scottish Public Services Ombudsman (SPSO). She outlined the key performance indicators: outcomes, response times and extensions to stage one complaints acknowledging that the process in regard to extension did require to be tightened.

Professor Thomson also provided Members with some of the background detail on the main issues that had been raised in complaints, as well as the learning taken by the organisation. Mr Johnston offered the Committee's thanks for the comprehensive report and asked for the data for that to be brought to the Committee in reporting (i.e. cases where the complaint could not be resolved within 5 days and an extension had been agreed).

Action – L Thomson

Mrs Carmichael noted the report by the internal auditors which had been received by the Audit Committee, and the recommendations made. These had been to emphasise the need to share learning across the organisation, to ensure correct recording of date of receipt of complaint, and to follow the complainant's preferred communication route when responding.

NOTED

11 INCIDENT REPORTING AND PATIENT RESTRICTIONS

A report was submitted to the Committee, on behalf of the Medical Director, which provided an overview in respect of Incidents and Patient Restrictions within the third quarter of 2017/18. Professor Thomson led Members through the report, highlighting in particular the Patient Restrictions trend analysis included and Members were asked to note that episodes of physical restraint had increased due to the high level of clinical activity.

She also noted the decrease in seclusions over the past quarter, and picked out the key points in Incident reporting which had shown a decrease in numbers overall. There had been an increase in the number of self- harming during this quarter. This had been fed back to the individual RMO for each patients and Professor Thomson provided the Committee with further reassurance that she

had requested that the clinical team report to her in this regard.

There was further discussion on the search process for illegal substances as well as closed visiting procedures (i.e. when no physical contact between the patient and visitor) should this be considered appropriate.

Mr Johnston raised the timescale for reporting of CIRs and SUIs as evidenced in the report and which was of concern. Mr Crichton acknowledged that reporting times required significant improvement, and provided further detail in terms of staffing capacity issues within the department presently. He provided assurance to the Committee that the management team were sighted on this and that every effort was being made to improve the position. Members agreed that this was of concern and requested a further update in this regard.

Following this discussion, it was agreed that a Log of Areas of Concern should be provided and updated at each meeting of the Committee.

Actions – S Smith

NOTED

12 DISCUSSION: REHABILITATION THERAPIES SERVICE

Ms C Totten, Lead AHP, was in attendance for this item to provide the Committee with an overview of the AHP service within TSH and her own role as service lead. She detailed some of the key achievements for the service including the setting up of an Arts Therapies meeting as a group shared referral process, integrated work with the Patient Learning Centre and involvement in planning patient activity days. She also highlighted the development of a falls bundle, which was being progressed through consultation.

Ms Totten provided Members with an outline of the Service Strategy for 2017 to 2020, with key priorities being Health Inequalities, Hub Activity, Ward Activity and maximising opportunities within the Skye Centre. In response to a query form Mrs Whitehead, Ms Totten provided further detail in how the service was looking to widen opportunities for engagement e.g. walking in grounds. She emphasised the importance of making best use of the Skye Centre, as activities within ward areas could be limited by the space available there.

As part of her presentation, Ms Totten described the vision for the service for the future. The emphasis would be on better use of standardised assessment and shared treatment planning to ensure that activity provision met patient need. Focus would be on more efficient and effective practice, especially use of activity space in the Skye centre. This would be progressed in conjunction with AHP involvement in planning use of Hub space, as part of MDT working. There was also focus on engagement with the third sector, with volunteer placements in the Skye centre.

Ms Totten advised that review of Arts Therapy provision would be required, and work was ongoing in this regard. She acknowledged the need to improve data recording methodology to provide clarity in this area.

Ms Totten invited Members to consider and help shape the structure of the Rehabilitation Therapies Report to the Committee.

Mr Richards thanked Ms Totten for the presentation, and agreed that although previous reports had help to demonstrate some improvement in this area, it would be helpful to reconsider the structure of the report to gain clarity and balance the shape of the report for the Committee.

Mrs Whitehead requested more detail on Arts Therapy and Ms Totten clarified that this included music, drama and art through a variety of mediums and the importance of this for patient engagement. However, the costs of music therapy had increased and, going forward, further

consideration of how this was delivered would be required.

Professor Thomson underlined how well standardised assessments were working and agreed that a more integrated approach across MDT teams with new ways of working to support this. Mr Crichton agreed that further planning was required to help join up resources and find a practical solution to supporting Hub activity. There was discussion around current modelling required three staff members (with at least one nurse) to one patient to support Hub activity. Mr Crichton emphasised the need to consider this carefully and in the context of detailed assessment of health and safety, and advised that this was being progressed by senior management. It was agreed that an update should come back to the Committee.

Action – M Richards

Mr Johnston thanked Ms Totten for her presentation which had been very well received by Members and had provided a useful basis for their discussion.

NOTED

13 WORKPLAN

Members received and noted the proposed Clinical Governance Committee Plan of Work 2017-2018.

Updates from today's meeting would be included as follows:

- Report from Mental Health Practice Steering Group – November 2018.
- Update on Psychological Therapies Outcomes – November 2018.
- Progress for AHP service – update – August 2018.

Action: S Smith

14 ANY OTHER BUSINESS

a) The discussion item for next meeting would be either:

1. Clinical outcomes from the Recovery Plan 2017/18
2. Suicide Awareness and Prevention Policy

If (1) was brought to the Board Meeting in April 2018, the discussion topic would be (2).

Action: L Thomson

b) Consideration of information to be shared with Staff Governance Committee:

It was agreed that Duty of Candour should be shared with Staff Governance Committee as part of awareness for staff.

Action: L Thomson/M Smith

15 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 10 May 2018 at 9.45am in the Boardroom, The State Hospital, Carstairs.

The meeting concluded at 12.10pm

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 April 2018
Agenda Reference:	Item No: 12
Sponsoring Director:	John White, Interim Human Resources Director
Author(s):	Jean Byrne, Organisational Development Manager
Title of Report:	The National Health and Social Care Staff Experience Report 2017

1 SITUATION

The National Health and Social Care Staff Experience Report 2017 is a combination of the national results for both iMatter and the Dignity at Work Survey. Taken together, both of these surveys give a comprehensive picture of how engaged staff feel and what they experience at work. Each board has received a copy of the national report as well as their individual board report. A full copy of the report can be found at http://www.gov.scot/Resource/0053/00532256.pdf

2 BACKGROUND

i-Matter

The national iMatter report was brought to Staff Governance, SMT and the Board in August 2017. What this edition adds to our previous knowledge is a greater depth of comparison across individual boards as well as allowing each board to share a story from their iMatter journey. The State Hospital was unable to do this but will work on ensuring this happens for the next report.
Our response rate ranked amongst the four highest across Scotland. In addition, our EEI score is comparable with many of the other boards. We are also the third highest in terms of agreeing action plans. So we have performed strongly in terms of process.
We also performed well in terms of the percentage of green reports we received – 72.9% was the seventh highest. However, when we compare our performance across yellow reports, we have the second highest number across NHS Scotland with a percentage of 10.4%.

Dignity at Work

The national Dignity at Work report provides us with an overview of staff experience across all of the health boards, including unfair discrimination, bullying/harassment, abuse/violence, whistleblowing and resourcing.
In general, there are many positive messages for The State Hospital. There are also areas where improvements can be made.

3 ASSESSMENT

This report highlights the top level results and demonstrates how we compare nationally.

Excellent response rate

- The State Hospital achieved a response rate of 52%. The national response rate was 36%. This was the fourth highest response rate across Scotland. It is also worth pointing out that our 2015 response rate in the national Staff Survey was 34%! So, this is a great improvement.
- We are also the organisation with the biggest increase in responses.

National response rates to questions

In the national report, the questions that got the lowest number of responses were the questions relating to:

- The demographic around sexuality
- Emotional/verbal abuse from patients/service users or other members of the public
- Physical violence from patients/service users or other members of the public.

The questions that received the highest number of responses related to:

- Unfair discrimination from manager
- Bullying and harassment from manager.

The State Hospital response rate did not vary much between questions, with all questions being answered equally fully.

Summary overview of our performance

The national report gives us the opportunity to benchmark our performance against the other health boards (see pages 43-51). The following four tables illustrate our performance, when compared nationally, across all of the key areas within the report.

- Unfair discrimination or bullying and harassment - our figures are comparable with figures from across the other health boards. The area of greatest disparity is in staff reporting of issues.

Table 1

From managers	*From colleagues*
1. 92% of State Hospital staff stated that they had <u>not</u> experienced unfair discrimination from managers compared with 95% nationally. 2. 21% of staff reported these incidents compared with 28% nationally. 3. 17% of staff were satisfied with the response they received to reporting compared with 18% nationally.	1. 92% of State Hospital staff stated that they had <u>not</u> experienced unfair discrimination from colleagues compared with 94% nationally. 2. 27% of staff reported these incidents compared with 34% nationally. 3. 25% of staff were satisfied with the response they received to reporting compared with 26% nationally

- Bullying and harassment – our figures are comparable with other boards except in the area of satisfaction with the responses to reporting where we can see a significant difference.

Table 2

From managers	*From colleagues*
1. 88% of State Hospital staff stated that they had not experienced bullying and harassment from managers compared with 91% nationally. 2. 22% of staff reported these incidents compared with 25% nationally. 3. 10% of staff were satisfied with the response they received to reporting compared with 27% nationally.	1. 84% of State Hospital staff stated that they had not experienced bullying and harassment from colleagues compared with 85% nationally. 2. 39% of staff reported these incidents compared with 43% nationally. 3. 9% of staff were satisfied with the response they received to reporting compared with 38% nationally

- Abuse and violence – there is a wider difference between the experience of State Hospital staff and other health boards in their experience of abuse and violence. However, The State Hospital outperforms most other health boards in terms of reporting and satisfaction.

Table 3

Emotional/verbal abuse from patients/public	*Physical violence from patients/public*
1. 64% of State Hospital staff stated that they had not experienced emotional/verbal abuse compared with 71% nationally. 2. 81% of staff reported these incidents compared with 50% nationally. 3. 76% of staff were satisfied with the response they received to reporting compared with 65% nationally.	1. 75% of State Hospital staff stated that they had not experienced physical violence compared with 93% nationally. 2. 100% of staff reported these incidents compared with 79% nationally. 3. 74% of staff were satisfied with the response they received to reporting compared with 60% nationally

- Whistleblowing and resourcing – staff feel less able to speak up and challenge than their national counterparts. However, they feel more positive around issues of resourcing and staffing.

Table 4

53% of State Hospital staff stated they feel safe to challenge and speak up compared with 65% nationally	53% of staff stated that they could meet conflicting demands on time at work compared with 46% nationally	33% of staff stated there are enough staff for them to do the job properly compared with 34% nationally

Staff groupings

The national report breaks responses down according to staff demographics across all of the health boards (pages 56 onward). However, some of the staff groupings at The State Hospital are quite small, making it more of a challenge to interpret the figures. Nonetheless, the following data are not unexpected:

- Staff experiences of emotional/verbal abuse are higher among nursing, senior managers and AHPs than the national figures.
- Physical violence experienced from patients/carers/public is also much higher among nursing and 'other therapeutic'.
- Interestingly, physical violence from patients has been reported 100% of the time, interestingly; however, emotional/verbal abuse is not always reported.

4 RECOMMENDATIONS

1. SMT will consider the findings of the Dignity at Work survey and consider what actions it might need to take.
2. The key messages will be communicated to all managers along with the link to the national report.
3. Managers will communicate the key findings to their staff.
4. A staff briefing will be issued to enhance communication of the key messages.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports the ongoing implementation of 2020 Workforce Vision
Workforce Implications	Time required to hold organisational conversations and to feed back.
Financial Implications	N/A
Route to Partnership Forum Which groups were involved in contributing to the paper and Recommendations.	Paper prepared by OD Manager.
Risk Assessment (Outline any significant risks and associated mitigation)	
Assessment of Impact on Patient Experience	It is well evidenced that demonstration of values is directly linked to a more positive patient and staff experience
Equality Impact Assessment	EIA Screened – no identified implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 April 2018
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Head of Management Accounts
Title of Report:	Financial Position as at 31 March 2018
Purpose of Report:	Update on current financial position

1 SITUATION

1.1 The Senior Team and the Board consider the Revenue and Capital plans, and financial monitoring. This report provides information on the financial performance to 31 March 2018.

1.2 The three-year financial plan for 2017/18 – 2019/20 is an integral part of the Board Local Delivery Plan (LDP). The LDP is the strategic plan, which sets out the agreed vision for service delivery and development for the Board, and sets out a balanced budget for 2017/18 based on achieving £1.402m efficiency savings, as referred to in the table in section 4.
Recognition of recurring posts, saved through recent workforce reviews, amounting to £0.315m have already been realised in the 2017/18 base budgets, so in effect that brings the total savings target to £1.717m.

1.3 National Boards are individually and collectively, through work streams, aiming to support and contribute £15m to the regional efficiency savings gap. £0.440m has been deducted (non-recurring) from our allocation in June 2017, as The State Hospital identified contribution and a new table has now been added to track this in section 4.3.

We have received some income relating to VAT changes on electricity, with HMRC still reviewing the change in VAT from 20% to 5% (any suggestion from HMRC re repayment would be appealed). Water rebates were also received and both of these unexpected windfalls contributed to the National Boards' efficiency savings gap.

2 BACKGROUND

2.1 **Revenue Resource Limit Outturn**
The Board is reporting an under spend position of £0.005m to 31 March 2018.
There was a favourable movement in month of £0.330k. The following have contributed to breakeven –

- Recent Nursing measures influenced a reduction in overtime paid in March, and due to be paid in April (reducing the year-end accrual).

- Cutting back of non-key expenditure in the final weeks of the year, although some of these costs will occur in 2018/19.
- A thorough review of year-end accruals, taking benefits where possible and subject to audit consultation.
- RHI income accrued for the last quarter.
- Director recharge for 2 days per week.
- As noted earlier we were expecting further electricity arrears – but this is still under review with HMRC.

The current overall position is summarised in the table below –

Board Functions	Annual Budget	YTD Period Budget	YTD Actuals	YTD Variance (budget - actual)	Establishment budget	Period WTE
Cumulative to period 12 - Mar 18	£'k	£'k	£'k	£'k	wte	wte
Corporate Functions Total	**9,230**	**9,230**	**8,550**	**679**	**90.03**	**78.15**
Medical	2,157	2,157	1,849	309	14.78	13.93
Nursing and AHP's	17,910	17,910	19,009	(1,099)	384.88	384.67
Security and Facilities	5,640	5,640	5,524	116	126.63	123.98
Board Functions Total	**34,937**	**34,937**	**34,931**	**5**	**616.32**	**600.73**

2.2 **Outturn**

The forecast outturn trajectory to date (March 2018 as set in the LDP) is breakeven, with a slight under spend due to above measures.
The deduction of savings for Regional boards has had a major impact in year.
Nursing overtime continues to be a critical factor, however the windfalls for electricity and water arrears, CNORIS income, and carry forward RRL, have contributed significantly to these pressures.

2.3 **Revenue Resources**

The annual budget £34.937m matches the Revenue allocations received, and anticipated AME, from Scottish Government.

3 ASSESSMENT
YEAR TO DATE POSITION BOARD FUNCTIONS

3.1 **Medical Services**

Annual Budget £2.2m. Year to date under spend of £0.309m.
This is mainly in connection with reductions to EPAs, and increased external sessions recharged out – since base budget was set, these ongoing changes are to reflect savings being made due to the ward closure. There are also underspends in connection with accruals reduction for recharges from other Boards for trainee Doctors.

3.2 **Nursing and AHPs – see table overleaf.**

Annual Budget £17.9m. Year to date over spend of £1.099m.

Nursing & AHP's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 12	Budget WTE	Actual WTE
Ward Nursing	14,016	14,016	15,488	(1,472)	294.40	302.59
Nursing Resources	90	90	118	(29)	2.00	2.00
H & C Admin	689	689	647	42	22.17	21.26
Directors PAs	227	227	223	4	5.60	5.60
Skye Centre	1,596	1,596	1,392	204	38.33	35.44
AHPs	576	576	493	82	12.98	10.81
Advocacy	142	142	147	(5)	0.00	0.00
Involvement & Equality	209	209	158	51	3.40	2.47
Nursing Support	365	365	342	23	6.00	4.50
Total Nursing and AHP's	**17,910**	**17,910**	**19,009**	**(1,099)**	**384.88**	**384.67**

The £'s includes NI'ers @ 11%

2017/18 Ward Nursing Hours		
Period	**Overtime Hours**	**Excess Hours**
APR	3,732	734
MAY	3,010	707
JUN	4,046	464
JUL	5,144	568
AUG	6,822	848
SEPT	6,885	496
OCT	6,694	552
NOV	6,587	377
DEC	5,433	472
JAN	6,628	366
FEB	6,532	431
MAR	2,181	219
TOTAL	**63,694**	**6,234**

2016/17 Ward Nursing Hours		
Period	Overtime Hours	Excess Hours
APR	5,110	850
MAY	3,476	684
JUN	3,549	654
JUL	3,950	770
AUG	4,288	839
SEPT	4,620	960
OCT	4,524	904
NOV	4,177	685
DEC	2,812	640
JAN	4,497	599
FEB	5,027	882
MAR	2,893	327
TOTAL	**48,923**	**8,793**

2017/18 Ward Nursing £s		
Period	**Overtime £**	**Excess £**
APR	93,077	11,283
MAY	75,198	10,553
JUN	100,626	7,136
JUL	130,226	8,526
AUG	174,100	12,473
SEPT	177,335	7,781
OCT	177,187	8,072
NOV	168,648	6,058
DEC	137,775	7,646
JAN	175,417	5,768
FEB	172,113	7,046
MAR	56,952	3,446
TOTAL	**1,638,654**	**95,788**

2016/17 Ward Nursing £'s		
Period	Overtime £	Excess £
APR	130,693	12,458
MAY	86,752	10,475
JUN	85,285	10,137
JUL	97,849	11,299
AUG	106,060	12,323
SEP	118,216	14,246
OCT	116,469	13,695
NOV	105,099	10,326
DEC	67,839	9,223
JAN	116,246	9,040
FEB	124,971	12,980
MAR	73,143	4,574
TOTAL	**1,228,621**	**130,775**

Memo: £0.300m budget for Nursing overtime.

Ward Nursing The Nursing over spend continues but as noted above the favourable financial effect of the changes in practice for February and March will be realised in March and April.

In addition to these statistics, on a weekly basis the Directors group look at activity data collated for nursing establishment, patient outings/escorting, training, and facility time.
This data will be considered within the review now underway of Nursing Resource Utilisation.

Some of the pressure is also to do with programmed monthly savings not yet realised. However, there is some benefit of the ward closure in other disciplines.

Nursing Resources over spend is due to targeted savings not achieved.

Hub & Cluster Admin vacancies (offset with Nursing Resource over spend).

Others within this Directorate - Skye Centre, AHPs, I&E, and Nursing Support all have vacancies, which are helping to offset some of the Nursing pressure.

3.3 **Security and Facilities – see table below.**
Annual Budget £5.6m. Year to date under spend of £0.116m.

Security & Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 12	Budget WTE	Actual WTE
Facilities	4,092	4,092	3,966	125	85.86	81.23
Security	1,548	1,548	1,557	(9)	40.77	42.75
Total Security & Facilities	**5,640**	**5,640**	**5,524**	**116**	**126.63**	**123.98**

Facilities – expenditure was held back in contracts and miscellaneous expenditure as part of the year-end measures. There are vacancies in most other departments.

Security – new temporary secondment post for retirement resilience (currently funded from source department).
Savings slightly under achieved.

3.4 **Corporate Functions (Support Departments) – see table below.**
The total budget for Corporate Functions is £9.2m – reporting an under spend of £0.679m.

Corporate Functions	Annual Budget	YTD Period Budget	YTD Actuals	YTD Variance (budget - actual)	Establishment budget	Period WTE
Cumulative to period 12 - Mar 18	£'k	£'k	£'k	£'k	wte	wte
Cap Charges	2,760	2,760	2,752	8	0.00	0.00
Central Commitments	74	74	(13)	87	0.00	0.00
Misc Income	(288)	(288)	(410)	122	0.00	0.00
Chief Exec	3,057	3,057	2,759	298	38.57	32.54
Finance	2,833	2,833	2,736	97	38.13	33.07
Human Resources Directorate	792	792	725	67	13.33	12.54
Corporate Functions Total	**9,230**	**9,230**	**8,550**	**679**	**90.03**	**78.15**

Capital Charges slight underspend.

Central commitments / unachieved savings – most of the balance was to cover apprenticeship levy costs (new 17/18).

Miscellaneous Income – includes RHI income (last quarter accrued) less any transferred to match RHI spend in Estates. Electricity and water arrears. Benefit of write off accruals.

Chief Executive – vacancies in Psychology (in part to do with ward closures), benefit of the HR Director secondment only being filled 0.50wte.
Offset with Social Work backfill of maternity leave has effect on under achieved savings.

Forensic Network & School of Forensic Mental Health sits within this Directorate, the Scottish Government earmark this funding. Some income has also been deferred to 2017/18, this is accrued monthly pending spend, to reflect the projected breakeven, there are also fluctuations due to timing of course income and expenditure, also accrued.

Finance – benefit from CNORIS Income and vacancies. Research now coded here and slightly under spent. These underspends compensate for the under achieved savings within ehealth.

Human Resources – mainly underspent in mandatory course fees coded to the Learning Centre, and ongoing vacancies in various departments within the Directorate.

4 EFFICIENCY SAVINGS TARGET

4.1 To balance the financial plan in 2017/18 the Board was required to release £1.717m of cash from budgets through efficiency savings, as noted in 1.2 above, £0.315m was recognised in the recurring base budgets, with £1.402m savings to be realised in year.

4.2 The following table tracks the LDP savings, over achieved by £0.256m year to date.

Savings Annual Target LDP	Savings Annual Target LDP			Savings Achieved YTD, as at Mar 18			Savings still to be achieved / (over achieved)by year end		
	2017-18			2017-18			2017-18		
	Rec £000s	Non-Rec £000s	Total £000s	Rec £000s	Non-Rec £000s	Total £000s	Rec £000s	Non-Rec £000s	Total £000s
Efficiency & Productivity Workstreams:									
Service productivity	51	29	80		(3)	(3)	51	26	77
Drugs & Prescribing	0	30	30		(77)	(77)	0	(47)	(47)
Procurement	0	0	0			0	0	0	0
Workforce	237	526	763	(6)	(1,115)	(1,121)	231	(589)	(358)
Support Services (Non-Clinical)	89	69	158	(80)	(42)	(122)	9	27	36
Estates & Facilities	56	115	171	(17)	(96)	(113)	39	20	59
Shared Services	0	0	0			0	0	0	0
Other	0	0	0			0	0	0	0
Unidentified Savings	200	0	200	(73)	(150)	(223)	127	(150)	(23)
Total In-Year Efficiency Savings	**633**	**769**	**1,402**	**(176)**	**(1,483)**	**(1,658)**	**457**	**(714)**	**(256)**
	Trajectory (1/12ths of LDP)			**633**	**769**	**1,402**			
	(under) / over achieved			**(457)**	**714**	**256**			

4.3 The following table tracks the new savings, towards the territorial Boards, post LDP, which were under achieved by £0.252m – resulting in a net savings overachievement of £0.004m.

Savings Annual Target Return of Savings - Part 1 (contribution to Territorial Boards)	Savings Annual Target LDP			Savings Achieved YTD, as at Mar 18			Savings still to be achieved / (over achieved)by year end		
	2017-18			2017-18			2017-18		
	Rec £000s	Non-Rec £000s	Total £000s	Rec £000s	Non-Rec £000s	Total £000s	Rec £000s	Non-Rec £000s	Total £000s
Unidentified initially		440	440			0	0	440	440
Estates & Facilities (Electricity VAT arrears)					(188)	(188)	0	(188)	(188)
Total In-Year Efficiency Savings	**0**	**440**	**440**	**0**	**(188)**	**(188)**	**0**	**252**	**252**

The total over achieved savings is £0.004m.

5 CAPITAL RESOURCE LIMIT

Capital allocations from Scottish Government amount to £0.750m.

	Annual Plan £'k	YTD Plan £'k	YTD Actual £'k	YTD Variance £'k
Estates	145	145	145	-
IM&T	141	141	141	-
Vehicles	47	47	47	(0)
Other equipment	189	172	172	(0)
Security Fence Dvpt	228	174	174	
TOTAL	**750**	**679**	**679**	**(0)**
Underspend at Mar 2018			**71**	

6 RECOMMENDATION

6.1 Revenue
Under spend of £0.005m.

The earlier adverse financial position had been caused principally by the increased costs of nursing staffing, together with an element of the additional pressure of the National Boards' savings.

A number of options regarding nursing spend were considered by the Senior Management Team at a meeting on Wednesday 7 February and these were taken forward.
In addition, all budget holders were closely engaged in reviewing remaining spending for all efficiencies, and all items going through Hospital procurement were scrutinised to remove non-essential spending.
All this hard work paid off and allowed us to come back in line with the projected breakeven position.
However, concerns should still be raised with the recurrence of the £0.440m territorial Boards savings deduction in 2018/19, especially going forward as some of these temporary measures will hit next year, and the levels of nursing overtime spend incurred in the first three quarters of 2017/18 will not be sustainable in 2018/19.

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

6.2 Capital
Under spend of £0.071m

The underspend relates to the timing of work on the security and perimeter redevelopment.

In recent weeks, agreement was reached for a project to proceed involving the installation of gas tanks that can be used to heat the hospital instead of oil when prices indicate it beneficial, for which there is still a £0.012m outstanding payment. On current prices, we would run on gas and save £52k in revenue costs per year, providing a payback period of just over 3 years. Planning permission was confirmed by South Lanarkshire Council not to be required, but due to the timing constraint and the lack of supplier options, the project was subject of a waiver.

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 financial implications – for information only
Route to Board Which groups were involved in contributing to the paper and recommendations?	Head of Management Accounts
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

Board Paper 18/18

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 April 2018
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Director of Nursing and AHPs
Title of Report:	Final Summary Report on Savings Plan Activity
Purpose of Report:	To update Board on progress against agreed actions set out in savings plan

1 SITUATION

This paper is the final report on the savings plan activity which was delivered from 12 February to 31st March 2018.

2 BACKGROUND

Following an extraordinary SMT which was held on 7 February 2018, a series of actions were agreed to support the Board achieving financial balance by the end of the financial year. The actions agreed were implemented from 12 February 2018.

Eight actions were agreed by the SMT for delivery:

	Action
1	Concentrating more of our Nurse staffing around the 9am to 5pm period, patients' plans of care being adjusted around the availability of these staff.
2	Skye Centre supporting the Hubs on a daily basis with four of their staff working in the wards.
3	The 'active day' model that has been tested in Lewis 2 will be rolled out as soon as possible to Iona 2.
4	Non-essential training suspended. All spending on non-essential training or study days for all staff will be suspended.
5	Non-essential rehabilitation outings being postponed.
6	Greater use being made of multi-professional staffing within the Hubs to ensure backfill for clinical outings and pre-transfer activities.
7	Registered nursing staff who are PMVA level 2 trained and who are currently in non-ward roles being asked to make a front line contribution at ward level.
8	Suspension of secondments to the Nursing Practice Development Team.

Financially, it was projected that all of these actions would mitigate against the risk of continued spend on Nursing overtime, which during the month January was running in excess of £40,000 a week against a budget £6,000. Year to date spend on overtime and excess hours at the time of agreeing these measures was £1,674,000.

In the modelling that preceded the implementation of this plan, the highest impact action was action 1, with a projected weekly benefit of reducing care hours required by 1291 hours (£32,000 per week).

A monitoring process was established, with a weekly monitoring meeting held involving Nursing and Medical Directors, Lead Clinicians, Heads of Psychology and AHPs, Lead Nurses, and Skye Centre Manager, with regular feedback on monitoring also provided to the Mental Welfare Commission.

At the SMT meeting held on 14 March, progress against each savings action was reviewed, and it was discussed whether each action should stop, could be adjusted, or could reasonably continue. This is covered in the assessment section below.

3 ASSESSMENT

As of 18 April 2018 (date of this report), the status of the actions agreed by the SMT is as follows:

Action		Update
1	Concentrating more of our Nurse staffing around the 9am to 5pm period, patients' plans of care being adjusted around the availability of these staff.	Agreed that the use of shared care teams would cease. 9-5 teams will still be used where clinically supported.
2	Skye Centre supporting the Hubs on a daily basis with four of their staff working in the wards.	Agreed that this would continue up until 13 April
3	The 'active day' model that has been tested in Lewis 2 will be rolled out as soon as possible to Iona 2.	Model fully implemented, running 4 days a week.
4	Non-essential training suspended. All spending on non-essential training or study days for all staff will be suspended.	Training re-instated from 1 April. Focus on training blocks going forward to avoid peak annual leave times
5	Non-essential rehabilitation outings being postponed.	Outings reinstated, but with further monitoring and review of outings activity
6	Greater use being made of multi-professional staffing within the Hubs to ensure backfill for clinical outings and pre-transfer activities.	Ongoing focus on ensuring best use of multi professional resource.
7	Registered nursing staff who are PMVA level 2 trained and who are currently in non-ward roles being asked to make a front line contribution at ward level.	This has now stopped. More work required on how we might make best use of PMVA level 2 trained staff on sustainable basis
8	Suspension of secondments to the Nursing Practice Development Team.	Suspension of secondments lifted.

With regard to the specific monitoring of impact, the table below sets out the areas being monitored on a weekly basis for the duration of the delivery of the savings plan. It was agreed to stand down this meeting on Monday 26 March.

Individual care issues:	6 patients had been affected by the changes which had been introduced, over the course of the savings plan. Care was monitored, with hours of direct engagement recorded. No significant detriment to patient care was been reported, indeed benefit reported in some cases through focus on more structured engagement.
Complaints/feedback received:	5 complaints were received during the first week of the changes being introduced. No further complaints were received and the outcome of these complaints will be reported in the Q4 learning from feedback report. No concerns were reported to MWC.
Overtime usage	There were 0 hours of overtime used between 12 February and 10 March. Overtime costs for February were £57,000, with a further £35,000 incurred in March 2018. This compares to an average monthly spend of £144,000, with peak one month spend in the financial year of £177,000.
Seclusion events recorded	Nil.
Reported incidents relating to patients on L3 observation	Nil.
Skye Centre closures	The Skye Centre are continuing to provide 4 staff to the Hubs each day this will end on 13 April. The impact on departmental opening, was between 4 and 7 additional closures per week.
Variation from planned delivery of AHP or Psychology sessions	No significant impact reported.
Variation from policy (e.g. SRK staffing)	One variance reported linked directly to this plan.

This plan has delivered the financial benefit anticipated, in that it has mitigated against excessive pressure on Nursing overtime. Total overtime costs for the months of February and March were £92,000, compared to £348,000 in December and January, a difference of £256,000 or a 73% reduction in potential costs. There was a period between 12 February and 10 March when there was no overtime incurred at all. This was delivered through a high level of flexibility and good will being shown by Nursing staff, who agreed in the short term to vary from their normal shift patterns.

It is important to note that some of the adjustments made during this recovery period were unsustainable. Having, for example, shared care teams for our patients did result in a more restrictive approach to care, and the suspension of training for staff was clearly unsustainable beyond the very short term.

We will now move to bring forward a plan of work to ensure sustainability going forward, and which will set out options and actions primarily related to our service delivery model and workforce. This plan is the subject of a separate paper to the Board.

4 RECOMMENDATION

The Board is invited to:

1. **Note** the update on the actions taken to date, the delivery against these, and the financial benefits delivered.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports delivery of balanced budget in short term. Looking forward, will support sustainable service delivery.
Workforce Implications	Covered in sections 2 and 3 of report
Financial Implications	Actions set out are addressing projected overspend and need to ensure sustainability in 18/19.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Update following previous SMT discussions and decisions.
Risk Assessment (Outline any significant risks and associated mitigation)	Financial, patient experience and reputational risks. Regular monitoring and reporting systems were in place during the delivery of this plan.
Assessment of Impact on Stakeholder Experience	Assessed through weekly monitoring process.
Equality Impact Assessment	Not completed.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 April 2018
Agenda Reference:	Item No: 17
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Director of Finance and Performance Management
Title of Report:	Annual Operational Plan
Purpose of Report:	Update on submission of draft plan to SG

1 SITUATION

In previous years, the Local Delivery Plan ("LDP") has been a high level strategic plan covering a 3 or 5-year period. The State Hospital has had an LDP in place now since 2006, although the format and information therein has changed in that time. An LDP was submitted in 2017, and then later in that year a combined LDP was collated on behalf of the 8 National ("Special") Boards.

In February 2018, instruction was received from SG that the individual board LDP was to be replaced by a draft Annual Operational Plan.

2 BACKGROUND

The instruction received in 2018 is that as a "transitional step" while health and social care planning (especially re IJBs) is progressed at SG level, the Local Delivery Plan process has been replaced by a request for each Board to submit a draft Annual Operational Plan for 2018-19 (where relevant shared and aligned with the strategic plans of the relevant IJBs). This was to focus primarily on performance, high-level finance and workforce, and was to be a short, focussed document, drawing together key planning assumptions which reflect the local system priorities.

3 ASSESSMENT

The draft Annual Operational Plan was submitted on schedule to the Scottish Government, and the Chief Executive and the Finance and Performance Management Director are scheduled to have a teleconference on Monday 23 April as part of SG's programme to discuss the key aspects of all Operational Plans with each individual board.

4 RECOMMENDATION

The Board is asked to note the draft Annual Operational Plan and to highlight any comments or revisions.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Draft Operational Plan replaces, for the time being, the LDP document.
Workforce Implications	Noted in the draft Plan.
Financial Implications	No direct financial implications from the draft Plan – the draft Plan is however supported by the 2018/19 budget.
Route To SMT Which groups were involved in contributing to the paper and recommendations.	Senior Management Team Members; Clinical and Risk Governance representatives; Finance representatives.
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified.
Assessment of Impact On Patient Experience	None identified.
Equality Impact Assessment	No identified implications.

The State Hospitals Board for Scotland

Annual Operational Plan

2018 – 2019

Draft – 28 February 2018

1 Introduction

The State Hospitals Board for Scotland (the Hospital) provides assessment, treatment and care in conditions of high security for male patients with mental disorder who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting. It is a national service for Scotland and Northern Ireland.

The service has established a reputation for providing world class forensic mental health care. Visitors to the service both from home and abroad have been hugely positive about the patient centred approach and focus on recovery. Working with partners in our Forensic Network, we have established a reputation for high standards of care, innovative research and education and wish to maintain that in 2018/19.

Addressing health and social inequalities for our patient group is a major challenge. As a no-smoking facility and illicit drug and alcohol free area, the twin challenges of smoking and substance misuse are areas of existing success. Our primary challenge is patient obesity and its related physical health problems. The Board is building on existing measures to promote healthier choices for patients and will be delivering an agreed programme of initiatives over the coming year to improve the physical wellbeing of our patients.

Many of our patients have limited educational attainment linked to a range of factors in their lives prior to admission. This can lead to social exclusion and difficulty attaining employment. Patients benefit from access to recreational and educational facilities on site and are supported to develop their skills and educational attainment during their stay. We are committed to maintaining and improving opportunities for our patients to access both physical and educational activities.

The service has embraced the ambitions of the Scottish Patient Safety Programme and has been a key contributor to improvements in patient safety both locally and on the national stage. Work undertaken to introduce post-incident debriefing, for example, has led to a significant reduction in incidents of violence or aggression. We will be further developing our programme of patient safety work over the next year and investing in our staff's access to training in improvement methodology.

The State Hospitals Board for Scotland is fully committed to the principles, values and objectives articulated in *Everyone Matters: 2020 Workforce Vision*. We continue to set out our commitment to our staff to implementing this vision and making real improvements to the health of our organisation as a whole, and to the health of the people who work within it. We recognise that it is the people in our organisation who deliver the service and that the support and contribution of our employees will be crucial in delivering the objectives in this plan. We will be working in partnership to put a significant emphasis on maintaining and improving staff health and wellbeing and ensuring that our NHS values and behaviours are clearly visible to everyone who is part of our service. The introduction of the EASY service (Early Access to Support for You, a sickness support tool) in 2018 is helping us direct staff who are unwell to sources of help and support quickly and efficiently.

The financial landscape continues to be extremely challenging, and realising the continuous improvement that we are ambitious to achieve will mean working effectively not just as a local team, but across NHS Scotland. National Boards are now focussed on improving collaborative arrangements across Boards and ensuring that we are deploying our resources as effectively as we can to meet our patients' needs, driving out inefficiencies and improving quality. Our plan for 2018/19 builds on a shared vision with our staff about our key priorities and how we wish to achieve these now and in the future.

2 Vision, Service and Clinical Strategy

2.1 Vision

"To excel in the provision of high secure forensic mental health services, to develop and support the work of the Forensic Network, and to strive at being an exemplar employer."

2.2 Values and Aims

The State Hospital has adopted the core values of NHSScotland which are:
- Care and compassion.
- Dignity and respect.
- Openness, honesty and responsibility.
- Quality and teamwork

Our primary twin aims are:
- Provision of high quality, person centred, safe and effective care and treatment.
- Maintenance of a safe and secure environment that protects patients, staff and the public

2.3 Service Strategy

The Board is committed to fostering a forward-looking and "can do" organisational culture. We will ensure that a focus on continuous improvement underpins all of our activities and that our working environment is rich in educational and staff development opportunities. Quality care will be underpinned by person centred values and placing a high value on research and audit. We aim to attract and develop a highly skilled and resilient workforce; where the role of the multi-disciplinary team is central to delivery of high quality care and the experience and feedback of our patients / visitors and staff actively shapes our service.

Current challenges
Health Inequalities
- Physical health inequalities for our patient group is significant; reducing obesity and increasing physical activity are key outcomes in addressing this issue.

Workforce
- Exceptionally high levels of sickness absence – particularly in nursing – are lowering staff morale, are having a detrimental effect on staff training / development and are creating financial pressures, which are diverting resources away from direct patient care.
- A large proportion of staff are approaching retirement age which presents risks to the sustainability of our workforce and service if not proactively addressed.

Efficient Use of Our Resources
- We need to deploy our workforce more effectively if we are to continue to meet patients' needs and drive out unnecessary waste.
- We must ensure that we are working collaboratively and efficiently with other National and Territorial Boards to optimise opportunities for improved quality and reduced costs.

While we will strive to maintain our areas of success, the strategy for 2017-18 will focus on the 3 areas of challenge outlined above:
- Health Inequalities
- Staff attendance and resilience
- Efficient use of our resources

In order to ensure that we address these challenges and fulfil our vision for the service, it is essential that everyone working at The State Hospital has a clear understanding of our mission, our values and our organisational priorities. All managers will therefore be responsible for ensuring that their teams are informed and engaged with these priorities as they are relevant to their individual roles.

Monitoring systems are in place to review progress with these objectives through our governance framework. Performance targets have been aligned with the three quality ambitions in the national NHSScotland Healthcare Quality Strategy; person centred, safe and effective. Outcomes will be measured against agreed targets, and achieved through an incremental continuous improvement approach by way of the existing governance structure, e.g. Board and Committee Structures / Executive Appraisal.

The Hospital has established a set of Strategic Objectives as follows –

- Reduce obesity and increase physical activity.
- Complete implementation of the "Patients' Day" project.
- Reduce the use of additional hours.
- Optimise efficiency in clinical practice and clinical service delivery.
- Transform services to optimise efficiency whilst maintaining quality.
- Identify ways of generating more income.
- Promote attendance and reduce sickness absence.
- Support a forward looking culture.
- Create conditions for supporting quality assurance, quality improvement and change.
- Look at ways of better utilising technology to support the national digital agenda.
- Explore more cost effective stewardship of assets and resources.
- Develop effective workforce and succession planning strategies and measures that will address identified rapid turnover in the future.
- Explore options for effective shared services and resilience building through enhanced collaborative working both internally and externally.
- Ensure opportunities to develop the whole workforce are maximised; focussing on leadership development and the review of workforce models to ensure a sustainable, skilled and competent workforce.

These are detailed in the Hospital's Service Strategy, along with detail re delivery and lead responsibility – also aligning to Quality Ambition. A strategy session will take place annually to review and re-confirm or amend the long-term direction of the Hospital.

2.4 Clinical Strategy

Diagnosis is through assessment and formulation of patient risks and needs (psychological, physical, functional, social and spiritual). Each member of the multidisciplinary clinical team contributes. The aim is to address identified treatment needs to support recovery from mental disorder and reduce the risk of future offending. When appropriate, the aim will be for the patient to move on, whether that is return to prison, transfer to a lower security hospital, or, in rare cases, discharge into the community. This takes on board best practice recovery models and approaches. Risk assessment and management is integral.

Services for patients with an intellectual disability tend to be more intensive, at a slower pace, and have a greater need for consistency, communication and engagement.

A significant number of patients have one or more risk factors for cognitive impairment, secondary to longstanding severe schizophrenic illness, substance misuse (including alcohol) and acquired brain injury. Such impairment may impact on patients' understanding of, and compliance with, treatment. Assessments are carried out on admission and include specialist assessments for areas of specific identified difficulties. This should lead to services being tailored to meet individual need.

The need for processes to be in place to support early detection of dementia is addressed through cognitive screening as part of the psychology assessment undertaken on admission; and by clinical teams being alert to patients who present a reasonably high index of suspicion (certain patient groups are more susceptible). When required, a specialist neuro-psychology assessment is conducted.

Treatments and activities are provided within high secure conditions, and are tailored to meet the requirements of individual patient risk assessment and management plans.

The following 7 goals 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.

A strategic quality improvement/quality assurance work plan will be developed and published setting out the key actions for the delivery of the seven goals. In addition to this, each clinical area will publish a work plan that will be owned by them, drawing on specialist support where required. The delivery of the work plans will engage staff, patients, carers and volunteers. The State Hospital will build commitment to this agenda and create a culture of accountability for continuous quality.

Over the course of this strategy, a quality improvement education and learning framework will be devised to improve knowledge and skills across all staff groups within the Hospital.

The Board will maximise the use of quality improvement methodologies, using data for improvement as well as assurance and strive to learn from experience. It will instil ownership for delivery of safe, effective, person centred care, encouraging staff to manage local responses to feedback, raising issues and concerns, learning from adverse events and sharing learning with others.

2.4.1 Operational Delivery

Improvements in the quality of clinical care are best led by multi-disciplinary teams providing front line services. By providing accessible information relating to the quality of care (on a close to real time basis) we can support clinicians to focus their improvement activity in response to 'live' challenges and monitor the impact of changes made.

Whilst the clinical workforce is key to the provision of safe, effective and person-centred patient care, their role and contributions are only enabled with the support of the wider workforce. There is an absolute recognition that safety, quality and person centeredness is everyone's responsibility, and therefore every member of The State Hospital staff has a role to play.

Leaders and managers in all areas have particular responsibility as role models and enablers in the promotion of safety, quality and person centeredness and must demonstrate this through their everyday actions and behaviours.

Internal links and partnership working to support clinical quality are extensive. A number of specialist groups and committees have been set up to share and develop good practice and deliver elements of clinical quality. These committees and specialist groups have a dual reporting line: an operational management route to the Clinical Governance Group, and a governance route to either the Staff Governance Committee, Clinical Governance Committee, or Audit Committee.

Although service leads for quality assurance and improvement are in place, all individuals and teams are responsible for applying quality assurance and improvement into practice. This responsibility is demonstrated through:

- Professional Codes of Practice;
- Continuous professional development;
- Performance and appraisal review process;
- Revalidation;
- Improvement activity and measurement;
- Audit;
- Evidence Based Practice;
- Personal Reflection;
- Learning from adverse events, complaints and feedback.

2.4.2 Responsibility and Accountability

Individual directors have lead responsibility for specific elements relating to the Health and Social Care Standards and the Mental Health Strategy, including the development of strategies, policies and plans for their delivery.

Each lead Director is responsible for progress reports to the Board within their area of responsibility, including principle risks to achieving their objectives, their impact on the Board's objectives and plans for the year ahead. This is performance-managed through the Directors' objectives by the Chief Executive, followed by the Remuneration Committee.

The Clinical Governance Group, chaired by the Medical Director, has a standing agenda section devoted to action plans in order to ensure that continuous quality improvement is embedded within the organisation.

The Medical Director has Executive responsibility for Clinical Quality. The Medical Director attends and provides assurance to the Clinical Governance Committee, which monitors this Strategy, through regular reports including an annual Clinical Governance Report to the Board.

The Clinical Governance Committee ensures actions arising from clinical quality activities are implemented. The Committee has a comprehensive, rolling plan of work which ensures that all aspects of clinical governance are scrutinised by this group, and the Chair of the Clinical Governance Committee provides a progress report to the Board.

Elements of practice relating to staff professional development and support are reported to the Staff Governance Committee. However, arrangements are in place to ensure that issues impacting on patient care and treatment arising from staff governance arrangements are reported and managed through the clinical governance structure. These arrangements are reviewed annually.

The Board is responsible for ensuring that adequate resources are committed to deliver the strategic goals for clinical quality.

3 Financial Plan

Financial Planning is an integral part of the Operational Planning process. As part of this process each Board is required to submit an Operational Plan to Scottish Government by 28th February 2018

The State Hospitals Board for Scotland is forecast to meet their statutory financial targets as set out for March 2018 financial year end with no significant risks highlighted. These include the following limits which must not be exceeded:

1. Revenue Resource Limit (RRL) – resource funding for net revenue expenditure allocated by the Scottish Government for ongoing operations
2. Capital Resource Limit (CRL) – resource funding for net capital expenditure allocated by the Scottish Government for investment in fixed assets
3. Cash Requirement – cash required to fund the net payments for all ongoing operations and capital investment

In addition to this there is a requirement to generate efficiency savings year on year both in terms of cash releasing savings to match the increased costs and productivity savings to deliver against the increased demands of patient care including complexity, activity increases and the requirement to continually invest in technology and quality improvements.

Year on year the Board has successfully achieved or delivered in excess on its challenging Efficiency targets and for 2017/18 Efficiency savings delivered as at January 2018 were £1.096m against an LDP (Local Delivery Plan) target of £1.168m and efficiency projections forecast achieving our Board efficiency savings annual target.

3.1 2018/19 Scottish Government Budget

The financial plan incorporates the Scottish Government Pay Policy which recommends a 3% pay increase for public sector workers earning £30,000 or less and a cap of 2% on the increased pay bill for staff earning more than £30,000. There will be a cap on pay applied for highest paid, with a maximum cash increase of £1,600 for those earning above £80,000. The final pay settlement for NHS staff will of course be subject to the NHS pay reviews process as in previous years.

The Scottish Government Budget reflects the commitment that more than half of frontline spending will be in community health services by the end of this parliament. The 2018-19 funding is designed to support a further shift in the share of the frontline NHS budget dedicated to mental health and to primary, community and social care. It is expected that NHS Boards and Integration Authorities contribute to this Programme for Government commitment and it will be essential that this is clearly evidenced as part of plans for 2018-19. Whilst this is not directly relevant to this Board any opportunity to support this will be included within the Board financial and local delivery plans.

The key points from the Scottish budget announced that are reflected within the Board financial plans for 2018/19 are:

- The State Hospitals Board for Scotland will receive an uplift of 1%, similar to the other national ‘patient facing’ Boards
- The National Board savings requirement of £15 million in 2017-18 will be made recurring in 2018-19; the allocation of this to be agreed in advance of the new financial year.

3.2 Financial Planning 2018/19

The financial plan sets out the resources available to the Hospital and how these will be used, and includes regular funding planning assumptions as follows;

- Scottish Government RRL baseline budget as described within RRL allocation letter and 2018-19 Scottish Budget
- Scottish Government RRL budget includes the confirmed baseline funding uplift of 1%
- Reflects proposed change to Scottish Government Outcomes Framework funding with the removal of the e-health associated element towards a revised funding model with separate in-year allocation
- Planning assumption that central funding support will be provided above the first 1% of pay award for Agenda for Change grades only
- Savings contribution towards National Boards' £15m requirement continuing recurrently as at 2018-19 value
- Continued support towards eHealth leads and eHealth allocation from former Outcomes Framework allocation
- Consultant Distinction award funding reflecting submission to the Scottish Advisory Committee on Distinction Awards (SACDA)
- Funding to support Implementation of Excellence in Care, MH (Mental Health) Secondment and Disabled Graduate scheme

The table below contains an extract of the one year financial plan – and the main assumptions, pressures and risks behind the plan are in the following section.

Operational Plan	**18/19**
Income	**£'k**
Core RRL	31,920
Non-core RRL - Capital Charges	2,760
Non-core RRL AME*	0
Total Income	**34,680**
Expenditure	
Pay	29,547
Capital Charges	2,760
AME* Provisions	0
Non-Pay	5,377
Income	(1,329)
Savings	(1,675)
Total Expenditure	**34,680**

*Annually Managed Expenditure

3.2.1 Overall position

The financial plan is balanced and delivery of a breakeven position during 2018/19 remains dependent upon realisation of the savings plan. Financial risks remain high around the workforce plan skill mix.

The plan is based on the indicative budgets set by the Scottish Government.

Savings targets continue to be extremely challenging – both for the Board individually, and collaboratively along with the other seven National Boards (see para.3.4)

3.2.2 Funding

As the public sector as a whole face funding cuts, the NHS has had some protection. This year the recurring increase in funding equates to 1%, with an additional contribution from UK consequential to an element of the proposed pay uplift. With planned payroll increases, incremental drift, and previous unfunded increases in NI (National Insurance) contributions, continued close budgetary scrutiny is required in order to cover the inflationary increases in costs and the required savings.

3.2.3 Savings

At this draft stage the savings have not yet been split by detail, only by total and Recurring or Non Recurring, as meetings with individual directorates to negotiate savings are currently being held.

Planned Savings	**2018/19**			**Risk Rating**		
	Rec	Non-rec	**Total**	**High**	**Med**	**Low**
	£000s	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Service redesign	0	0	0	0	0	0
Drugs and prescribing	0	20	20	0	0	20
Workforce	234	627	861	260	718	(117)
Procurement	0	0	0	0	0	0
Infrastructure	61	275	336	0	0	336
Other	13	5	18	0	0	18
Total Efficiency Savings workstreams	308	927	1,235	260	718	257
Financial management / corporate initiatives	0	0	0	0	0	0
Unidentified savings assumed delivered by y/e	0	440	440	440		
Total Core NHS Board Savings	308	1,367	1,675	700	718	257
Savings delegated to Integration Authorities	0	0	0	0	0	0

There are continued efficiency and productivity improvements sought which will be identified, managed and implemented through this period.

Savings targets for 2018/19 are particularly challenging as the Hospital manages the pressures noted in the next section.

3.2.4 Pressures

There are a number of pressures facing the Hospital over the coming year:

- Workforce Plan Numbers and Skill mix – due in part to the fall in staff turnover, it has not yet been fully possible to achieve the planned workforce numbers. The issues relate mainly to Nursing costs. The full workforce plan is currently under review.
- Pressure from any unfunded element of increased payroll costs, e.g. executive pay.
- Anticipated increases in rates and the apprenticeship levy.
- Utility costs continuing to rise, giving both a price and usage pressure in 2018/19.
- Non-capital associated costs related to the Perimeter Security and Enhanced Internal Security Systems Project – e.g. cost of staff escorting contractors.
- A number of costs associated with the Hospital estate, which are monitored closely and outturns adjusted accordingly. Ongoing evaluation of this impact over the coming years is assessed in order that budgetary pressures can be controlled.

There are also a number of specific risks associated with the plan:

- As noted above, the requirement for the National Boards to provide additional savings of £15m on a recurring basis in 2018/19.
- Savings plans – as stated above the operational running costs of the site are more than planned. A savings plan around the workforce, capital charges and supplies is followed; however additional savings may need to be made if the on-going costs are more than forecast. Also year on year it gets harder to identify workforce savings without impacting on patient care or security. If plans fall behind the financial balance could be at risk unless other non pay savings can be found, and currently a proportion of the savings for 2018/19 is still to be identified.
- The lack of any increase in capital funding potentially leaves equipment replacement at risk, as the formulae allocation will require close control and review to be able to cover any major equipment replacement programmes.

3.3 Capital – Property and Assets

The performance of assets is seen as critical by the Hospital. In order for the Hospital to meet its strategic objectives it is essential that existing and planned investment is targeted and effectively utilised. The Property and Asset Management Strategy (PAMS) reflects the following aims:

- To maintain and develop a high quality, sustainable site and assets that support the provision of high quality forensic mental health care in appropriate and secure facilities.
- To ensure that the operational performance of assets is appropriately recorded, monitored, reported and reviewed and, where appropriate improved.
- To ensure an effective asset management approach to risk management and service continuity.

The significant capital item forthcoming is the Perimeter Security and Enhanced Internal Security Systems Project in 2018/19-2020/21 – estimated at £7.2m. This is currently at tender / FBC (Full Business Case) stage, and the associated projected level of available revenue resource required for contractor escorting and project management will continue to present a major challenge for implementation of the Property and Asset Management Strategy, together with regular estates and security work, and IM&T (Information Management & Technology) equipment replacement programmes. Further work has taken place internally to re-examine security threats to the hospital and additional work commissioned to establish how those threats may be mitigated, including review of CCTV requirements, which will be reflected in the business case.

	2018-19 £000s	2019-20 £000s	2020-21 £000s	2021-22 £000s	2022-23 £000s
Capital Resource Limit (CRL)	269	269	269	269	269
Other centrally provided capital funding	4,313	1,565	1,302	-	-
Total Capital Resource Limit	4,582	1,834	1,571	269	269

3.4 Collaborative Working

Special/National Health Boards have again been tasked by the Scottish Government Health and Social Care Directorate (SGHSCD) to work together to identify ways to collectively standardise and share services with a target to reduce the operating costs of Special Boards by £15m in 2018/19 so that this can be reinvested in frontline NHSScotland priorities.

The Boards have agreed that:

- There is an absolute commitment to deliver the target on a sustainable basis
- There is scope to do this by continuing to develop collaborative working to create improved quality and efficiency
- There is further scope to develop the 'one for Scotland' approach and our work could be shared wider within the other Boards
- Rather than delivering this saving through a pro-rata share of the £15m apportioned in terms of the RRLs of each Board (or other arbitrary allocations), which was enacted in 2017/18; the plan is to deliver it through targeting real change in the way we deliver support services and providing a true and measurable once for Scotland basis

The work in delivering the target has therefore focused on four key workstreams:

1. Focus on transformation to deliver quality improvements and efficiencies across NHS Scotland to support the Health and Social Care Delivery Plan
2. Delivery of reduced operating costs through a critical review of support services to deliver sustainable savings
3. Delivery of cash releasing efficiency savings for territorial Boards
4. Management of non recurring spend and collaborative initiatives to deliver the target for 18/19 whilst the workplans in 1 and 2 deliver more sustainable quality improvements and reduced costs.

3.5 Security

The Hospital's secure environment is provided by three domains of Security:

- Physical security.
- Procedural security.
- Relational security.

Physical security is provided through high quality physical barriers and sophisticated electronic detection and observation systems.

Procedural security is provided through Policies, Procedures and working practice.

Relational security is provided by clinical staff working closely with patients to deal with illness and offending behaviour. The Clinical Model sets out how the hospital delivers safe and effective relational security as an integral part of its clinical work. To assist in this the Security Department has Clinical Security Liaison Managers working as an integral part of Clinical Teams.

The Hospital has its own Security Standards, which are aligned to the national High Secure Care Standards produced by the Forensic Network and adopted as national policy.

Compliance with Security Standards is audited by the Forensic Network and an external advisor. At the time of the most recent audit a small percentage of non-compliant areas were identified, for which actions have been taken to address; at the time these did not present any significant risk to the security or safety of the Hospital.

3.6 Efficiency and Productivity

The Hospital is committed to supporting the drive for efficiency and productivity. The Hospital's savings targets have been met in each of the recent years.

In future years, it is very likely that the Hospital will have increasing difficulty generating the same level of cash releasing savings. In order to ensure that service delivery can continue to improve and develop, the focus will need to move to improvements in operational productivity. This will require new approaches to driving and monitoring efficiency and productivity.

The Hospital's strategy, which us under review currently, will incorporate the essential elements of the Sustainability & Value Programme, 2020 Vision, and the Health and Social Care Delivery Plan. Current challenges include –

- Physical health inequality of our patients.
- Redeployment of resources to meet patient's needs and drive out inefficiencies.
- Requirements for recurring savings.
- Excessively high levels of staff sickness.
- High proportion of staff reaching retirement age.
- Proactively support the National Strategy in relation to Special Boards through collaborative working.

4 Health Improvement

The ultimate aim is to meet patients' mental health needs, enabling, when appropriate, the patient to move onto another setting. Patients often have very significant physical health needs (related to risk taking behaviours such as substance misuse; or consequences of treatment over a prolonged time in institutional care); or are living with the effect of long term conditions. There are many contributory factors involved such as: lack of exercise, obesity, complications of psychotropic medication, and the consequences of a self-selected poor diet. For some years now, the Hospital has been a smoke free environment.

4.1 Mental Health

The Hospital uses a variety of measures to indicate the effective management of mental health at an individual patient level:

- The ability to agree discharge / transfer safely to another setting.
- Patterns and trends of historic risk information such as violent and aggressive behaviour.
- Improvement in the BEST (Behavioural Status) nursing index score, and in the PECC (Psychosis Evaluation tool for Common use by Caregivers).
- Improvement in the formulation and management of risk profile of patients. Reduction in dynamic risk factors can be demonstrated on the clinical and risk items of the regularly updated HCR-20 assessments. (HCR-20 is a tool to manage risk of violence assessment and planning (Historical Clinical Risk -20))
- For intellectual disability patients a more dynamic measurement of progress in relation to the management of risks is evidenced through the DRAMS (Dynamic Risk Assessment and Management System) tool. This assessment should be reviewed at minimum, monthly, by the key worker.
- The psychology service is utilising the CORE (Clinical Outcomes for Routine Evaluation) system which is a short self-report measure of mental health and wellbeing outcomes that will be used nationally to evaluate psychological therapies.
- Reduction in frequency and intensity of levels of observation.
- Individual patients being assessed fit for grounds access whether full or partial.
- Monitoring of agreed mental health outcome measures.

4.2 Physical Health

The Hospital remains concerned to ensure that patients are encouraged and supported to adopt a healthy lifestyle particularly in relation to smoking, activity, and nutrition. Proactive assessment of significant risk factors can lead to improved outcomes for long term conditions. An approach which supports self management is crucial to a better long term outcome, which means that education plays an important part in improving health.

5 Governance

The governance and management landscape is increasingly complex both nationally and locally. One of the Hospital's local quality commitments is to improve meeting effectiveness but this is only a small part of what is required. The national Outcomes Framework and the national Quality Strategy are twin drivers towards more outcome based approaches rather than process based approaches.

5.1 Governance and Management Arrangements

There are three statutory governance strands for Boards and the governance structure is set up to deal with these through the Clinical Governance, Staff Governance and Audit Committees. Management is based around the clinical teams, reporting to the senior management team.

Leadership walkrounds will continue in 2018/19 – involving the Executive Directors, the Senior Management Team, the Patient Safety Steering Group, and the non-executive Directors by invitation. Actions arising are followed up, and reviewed at later walkrounds and at SMT (Senior Management Team).

Corporate document standards are in place to help streamline the flow of documentation, and the group and committee structures within the Hospital are regularly reviewed to streamline, rationalise and simplify meeting arrangements so that these are fit for purpose.

The corporate risk register is reviewed annually by the Board and quarterly by the Audit Committee. A full review of the Risk Register is being undertaken in 2018/19, led by internal audit and in consultation with non-executive directors, executive directors and senior management staff. In addition, local departmental risk registers are now in place, from which any identified high risk item is given consideration for the requirement to be reflected in the corporate register.

5.2 Staff Governance

The Staff Governance Standard provides the organisation with a platform to drive improvements in the management of staff. Our staff governance action plan identifies important actions we plan to take to ensure that the five objectives of the standard are met.

The staff governance action plan includes plans to achieve national targets such as:

- Management of sickness absence within 5% (4% national standard).
- All staff will have an annual Personal Development Planning and Review meeting with their line manager.

In addition to working towards the achievement of these standards, there are a number of local priorities which are important for 2018/19.

A workforce strategy has been developed for 2016/2021 to support the workforce profile for the current and future Hospital environment. The workstreams identified have been progressed as follows:

Sustainable Workforce;

- To review nursing workforce capacity in relation to core workforce requirements - completed
- To review AHP workforce and leadership arrangements - ongoing
- To review the Clinical Model / Patient Day - ongoing
- To improve Staff Attendance – ongoing

Capable Workforce:

- To develop a Leadership Programme to nurture leadership skills and support workforce capability – commenced in respect of Senior Charge Nurse Development with principles being implemented across all leaders within the organisation
- To develop secondment opportunities within the Forensic Network - ongoing

Quality Improvement Skills:

- To Develop a QI Strategy - ongoing

Effective Leadership:

- To develop recommendations to improve the nursing management and leadership arrangements - completed

These workstreams have been conducted in partnership and take into consideration the mix of professional skills required to work with the patient population, and ensure that the Clinical Model can be successfully delivered in the short, medium and long term.

In addition for 2018/19 the following additional workforce workstreams will be progressed:

- Review of Leadership arrangements for Administrative staff
- Review of Skye Centre staffing
- Human Resources Shared Services – National Boards and National Shared Services
- Review of Therapy provision
- Ongoing CRES (Cash Releasing Efficiency Savings) position and future prediction of workforce requirements

In line with the 2020 workforce vision for NHSScotland, adoption of the national values will continue to be progressed. This will include promotion of these values to ensure that they drive the decisions we make and the way our staff interact with each other.

5.3 Staff Experience and Engagement

iMatter
The Board has fully implemented the iMatter Staff Engagement Tool achieving a participation rate of 78% and an aggregated Board EEI (Employee Engagement Index) score of 76% in 2017/18. Both of these outcomes are extremely encouraging and have proven to be invaluable in enabling teams within the Hospital to develop action plans relevant to the matters that they see as being important to them.

From a Board perspective the feedback received has identified that Performance Management and Values and Behaviours remain the key areas to be progressed in 2018/19.

Further work is to be undertaken in partnership to provide feedback to staff in a way which clearly demonstrates the link between iMatter and Everyone Matters and also allows interactive discussion relating to embedding the national values within everything that we do.

Health and Social Care Staff Experience Report 2017
The board await publication of the above report which will present the 2017 iMatter results together with the national Dignity At Work Survey results. (due 2 March 2018) The results will be considered to identify areas of success and any concerns which may require improvement.

Partnership Working
The Board has well established partnership working arrangements within regard to the formal structure of the Partnership Forum and any associated sub-groups. A number of issues are being progressed in partnership with staff representatives including Promoting Attendance, Job Evaluation, Working Longer and the Workforce Review where there is a common understanding that these are matters which need to be progressed with this mutual approach.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 April 2018
Agenda Reference:	Item No: 17
Sponsoring Director:	Finance & Performance Management Director
Author(s):	Head of Financial Accounts
Title of Report:	Annual Review of Standing Documentation
Purpose of Report:	For review and approval

1 SITUATION

This report provides an update on proposed changes to Standing Documentation.

2 BACKGROUND

The Board is required, on an annual basis, to review and adopt any changes to Standing Documentation i.e. Standing Financial Instructions, Scheme of Delegation and Standing Orders.

The Audit Committee reviewed the documents at their April 2018 meeting and their recommendation was then noted for the Board's adoption.

3 ASSESSMENT

3.1 Standing Financial Instructions

There are six amendments proposed to the Standing Financial Instructions which include:

- Section 2.6.2 – removing Finance Director as depute Accountable Officer and replacing with Nursing & AHP Director.
- Section 3.6 - updating to change Monitoring Returns to Financial Performance Returns.
- Section 5.1.2 - adding this section with regards to the implementation of Project Bank Accounts.
- Section 9.6 – amending to reflect that payments to employees would be by bank credit only.
- Section 13.1.1 - adding reference to General Data Protection Regulations.
- Section 16.1.10 – adding to include new rules imposed in October 2017 around patient gambling.

3.2 Scheme of Delegation

There are three amendments proposed to the Scheme of Delegation which includes:

- Section 3 and 13.5 - updating to change financial monitoring forms to Financial Performance Returns.
- Section 6.2 - Clinical Effectiveness Strategy replaced with Quality Assurance and Improvement Strategy.
- Section11.8 – change title of authorised deputy to Information Governance and Data Security Officer.

3.3 Standing Orders

There are no amendments proposed to the Standing Orders.

4 RECOMMENDATION

Members are asked to approve the review of Standing Documentation.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

STANDING FINANCIAL INSTRUCTIONS

VERSION 14

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(c) 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.

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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 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 Finance Directors to design, implement and supervise systems of financial control and NHS Circular 1974 (Gen) 88 requires the Finance Director to:

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

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

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

1.2 Interpretation

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

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

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

1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

a) Formulating the financial strategy with due regard to Local Delivery 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".

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 Board' as part of the Board's Annual Accounts.

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

1.3.10 The Finance Director is responsible for:

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

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

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

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

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

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

- Standing Orders
- Standing Financial Instructions
- Scheme of Delegation
- Financial Operating Procedures

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 the period of the appointment of Interim Human Resources Director, responsibilities assigned to Human Resources Director within these Standing Financial Instructions and the Scheme of Delegation will be delegated to Chief Executive.

2 RESPONSIBILITIES OF CHIEF EXECUTIVE AS ACCOUNTABLE OFFICER

2.1 Introduction

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

2.1.2 Accountable Officers must comply with the terms of the Memorandum to National Health Service Accountable Officers, and any updated issued to them by the Principal Accountable Officer for the Scottish Government. The Memorandum was updated in July 2009.

2.2 General Responsibilities

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

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

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

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

2.3 Specific Responsibilities

2.3.1 The Accountable Officer must:

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

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

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

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

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

2.4 Advice to the Body

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

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

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

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

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

2.5 Appearance before the Public Audit Committee

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

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

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

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

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

2.6 Absence of Accountable Officer

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

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

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

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

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

3.1 Preparation and Approval of the Financial Plan and Budgets

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

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

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

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

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

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

3.2 Budgetary Delegation

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

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

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

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

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

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

3.3 Budgetary Control and Reporting

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

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

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

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

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

3.3.3 Each Budget Holder is responsible for ensuring that:

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

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

3.4 Cost Improvements and Income Generation

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

3.5 Capital Expenditure

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

3.6 Financial Performance Returns

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

4 ANNUAL ACCOUNTS AND REPORTS

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

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

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

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

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

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

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

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

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

5 BANK AND GOVERNMENT BANKING SERVICE (GBS)

5.1 General

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

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

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

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

5.2 Bank and GBS

5.2.1 The Finance Director is responsible for:

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

5.3 Banking Procedures

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

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

5.3.2 The Finance Director must advise the Board's bankers in writing of the conditions under which each account will be operated, including the Board's resolution. No other officer than the Finance Director shall open an account in the name of The State Hospital.

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

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

6.1 Income Systems

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

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

6.2 Fees and Charges

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

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

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

6.3 Debt Recovery

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

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

6.3.3 Overpayment when detected should be recovered.

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

6.4 Security of Cash, Cheques and Other Negotiable Instruments

6.4.1 The Finance Director is responsible for:

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

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

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

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

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

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

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

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

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

7 CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

7.1 Capital Investment

7.1.1 The Chief Executive:

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

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

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

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

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

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

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

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

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

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

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

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

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

7.2 Asset Registers

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

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

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

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

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

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

7.3 Security of Assets

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

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

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

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

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

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

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

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

7.3.8 Registers shall be maintained by the responsible officer for:

- Equipment on loan;
- Leased equipment.

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

7.4 Sale of Property, Plant and Equipment,

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

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

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

7.4.3 Managers must ensure that:

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

8 SERVICE LEVEL AGREEMENTS (SLAs)

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

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

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

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

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

9 TERMS OF SERVICE AND PAYMENT OF EXECUTIVE DIRECTORS AND EMPLOYEES

9.1 Remuneration and Terms of Service

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

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

9.1.3 The Remuneration Committee will:

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

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

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

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

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

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

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

9.2 Funded Establishment

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

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

9.3 Staff Appointments

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

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

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

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

9.4 Contracts of Employment

9.4.1 The Human Resources Director will be responsible for:

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

9.5 Pay and Payroll Documentation

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

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

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

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

9.6 Processing of Payroll

9.6.1 The Finance Director is responsible for:

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

9.6.2 The Finance Director will issue instructions regarding:

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

9.6.3 Appropriately nominated managers have delegated responsibility for:

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

9.7 Settlement Agreements, Early Retirement and Redundancy

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

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

9.8 Relocation Expenses

9.8.1 The Human Resources Director is responsible for:

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

9.9 Non Salary Rewards

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

- Cash bonuses
- Amenities and recreational facilities

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

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

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

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

10 NON-PAY EXPENDITURE

10.1 Delegation of Authority

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

10.1.2 The Finance Director will identify:

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

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

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

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

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

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

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

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

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

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

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

10.2.4 The Finance Director will:

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

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

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

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

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

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

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

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

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

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

10.2.6 Official Orders must:

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

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

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

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

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

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

10.3 Tendering Procedures

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

10.3.2 Directives by the Council of the European Union prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in Standing Orders and Standing Financial Instructions.

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

10.3.4 Where the estimated value of the contract is £10,000 or greater (exclusive of VAT), competitive tenders will be invited for:

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

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

a) The time scale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or
b) Specialist expertise is required and is available from only one source; or

c) The task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
d) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
e) The Product has been used within the hospital or other secure units and meets a security need. You must provide evidence of other similar products and the reason why these will not suit. (statement from Security Director is required)or
f) As provided for in the Scottish Capital Investment Manual.

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

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

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

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

10.3.10 Tendering procedures are set out in a separate Financial Operating Procedure.

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

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

10.3.13 Quotations should be in writing unless the Chief Executive or nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

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

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

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

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

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

10.4 Contracts

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

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

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

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

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

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

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

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

10.5 Grants and Similar Payments

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

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

10.6 In-house Services

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

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

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

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

10.6.4 The evaluation group shall make recommendations to the Board.

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

11 STORES AND RECEIPT OF GOODS

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

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

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

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

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

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

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

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

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

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

12 RISK MANAGEMENT AND INSURANCE

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

12.1.2 The programme of risk management shall include:

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

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

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

13 INFORMATION TECHNOLOGY

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

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

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

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

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

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

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

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

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

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

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

14 AUDIT

14.1 Audit Committee

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

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

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

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

14.2 Finance Director

14.2.1 The Finance Director is responsible for:

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

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

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

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

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

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

14.3 Internal Audit

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

14.3.2 Internal Audit will review, appraise and report upon:

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

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

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

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

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

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

14.4 External Audit

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

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

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

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

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

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

15 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

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

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

15.1.3 All unserviceable articles shall be:

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

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

15.2 Losses and Special Payments

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

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

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

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

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

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

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

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

15.2.7 The Finance Director shall maintain a Losses and Special Payments Register in which write-off action is recorded.

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

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

15.3.1 The Finance Director must prepare a 'fraud response plan', incorporating the requirements of HDL (2004) 23, updated by CEL(2009)18, that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

15.3.2 The Finance Director will be the nominated contact for the National Fraud Initiative (NFI) and will authorise the release of the required data for this purpose. The Finance Director may delegate the NFI investigation and reporting requirements, to suitable representatives. The Finance Director will ensure that all staff receive the required notifications that their information will be used for this purpose.

15.3.3 The following procedures should be followed, as a minimum, in cases of suspected theft, fraud, embezzlement, corruption or other financial irregularities to comply with Scottish Government Health Department Circular No HDL(2002)88 This procedure also applies to any non-public funds.

15.3.4 The Chief Executive has the responsibility to designate an officer within the Board with specific responsibility for co-ordinating action where there are reasonable grounds for believing that an item of property, including cash, has been stolen.

15.3.5 It is the designated officer's responsibility to inform as he/she deems appropriate the police, the Counter Fraud Services (CFS), the appropriate director, the Appointed Auditor and Internal Auditor where such an occurrence is suspected.

15.3.6 Where any officer of the Board has grounds to suspect that any of the above activities has occurred, his or her local manager should be notified without delay. Local managers should in turn immediately notify the Board's Finance Director, who should ensure consultation with the CFS, normally by the Fraud Liaison Officer. It is essential that preliminary enquiries are carried out in strict confidence and with as much speed as possible.

15.3.7 If, in exceptional circumstances, the Finance Director and the Fraud Liaison Officer are unavailable the local manager will report the circumstances to the Chief Executive who will be responsible for informing the CFS. As soon as possible thereafter the Director of Finance should be advised of the situation.

15.3.8 Where preliminary investigations suggest that prima facie grounds exist for believing that a criminal offence has been committed, the CFS will undertake the investigation, on behalf of, and in co-operation with, the Board. At all stages the Finance Director and the Fraud Liaison Officer will be kept informed of developments on such cases. All referrals to the CFS must also be copied to the Appointed Auditor.

15.3.9 The Chief Executive has also the responsibility to designate an officer within the Board as Counter Fraud Champion. The role is a strategic one, and focuses on spearheading change in culture and attitudes towards NHS fraud. Full background to this role is included within CEL 3 (2008). As such the role of Champion will complement the role of the Fraud Liaison Officer and includes responsibility for:

- Raising the profile of counter fraud initiatives and publicity
- Ensuring recommendations from investigation reports by NHSScotland Counter Fraud Services (CFS) are implemented
- Monitor implementation of CFS recommendations and ensure compliance with them
- Set clear guidelines and measures for monitoring the effectiveness of implementation.

15.4 Remedial action

15.4.1 As with all categories of loss, once the circumstances of a case are known the Finance Director will require to take immediate steps to ensure that so far as possible these do not recur. However, no such action will be taken if it would prove prejudicial to the effective prosecution of the case. It will be necessary to identify any defects in the control systems, which may have enabled the initial loss to occur, and to decide on any measures to prevent recurrence.

15.5 Reporting to the SGHSCD

15.5.1 Under Enhanced Reporting of NHS Fraud & Attempted Fraud CEL (2010)10 an annual return SFR18 must be completed, as part of the annual account process, to report all cases of Fraud to the SGHSCD. There may be occasions where the nature of scale of the alleged offence or the position of the person or persons involved, could give rise to national or local controversy and publicity. Moreover, there may be cases where the alleged fraud appears to have been of a particularly ingenious nature or where it concerns an organisation with which other health sector bodies may also have dealings. In all such cases, the SGHSCD must be notified of the main circumstance of the case at the same time as an approach is made to the CFS. However all significant or unusual incidents involving patients' finds or endowments should be reported to the SGHSCD.

15.6 Responses to Press Enquiries

15.6.1 Where the publicity surrounding a particular case of alleged financial irregularity attracts enquiries from the press or other media, the Chief Executive should ensure that the relevant officials are fully aware of the importance of avoiding issuing any statements, which may be regarded as prejudicial to the outcome of criminal proceedings.

15.7 Counter Fraud Services (CFS) – Access to Data

15.7.1 CFS work closely with the Board and may at times require access to evidence relating to ongoing investigations. Scottish Government Health & Social Care Directorate endorse that Boards should support the important role played by CFS and that any CFS staff acting on the Finance Director's behalf should be allowed access to the following:

- All records, documents and correspondence relating to relevant transactions
- At all reasonable times, access to any premises or land of The State Hospital
- The production or identification by any employee of the Board, cash, stores or other property under the employee's control

16 PATIENTS' PROPERTY

16.1.1 The Board has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients.

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Board will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.1.3 The Security Director must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.1.4 Where SGHSCD instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Finance Director.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained. Any payment by the Hospital towards funeral expenses should be approved by the Finance Director.

16.1.6 Staff should be informed, on appointment, formally in writing by the Human Resources Director and by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

16.1.8 The Finance Director shall prepare an abstract of receipts and payments of patients' private funds in the form laid down in the Health Board Accounts Manual. This abstract shall be audited independently and presented to the Audit Committee annually.

16.1.9 In general staff are not allowed to receive benefit from any patient's Will. If staff become aware of an intention to include themselves in a Will, staff should discourage such action. This should be reported to the appropriate manager. Anyone receiving a bequest should report this to their line manager to determine further action. Except in cases of the direst emergency, staff should not be involved in witnessing or otherwise in the making of a patient's Will. Any reference of such matters by a patient to a member of staff should immediately be communicated to Advocacy or the Board management, who may arrange for a local solicitor's services to be made available to the patient, if that is wished.

16.1.10 In order to comply with the Gambling Act 2005, patients are not allowed to gamble or place bets. Clinical staff should therefore not approve any requests from patients to withdraw funds for this purpose.

17 FUNDS HELD ON TRUST

17.1.1 Standing Orders (SOs) identify the Board's responsibilities as a corporate Trustee for the management of funds it holds on Trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Board, the Trustee responsibilities must be discharged separately and full recognition given to the dual accountabilities to the Charity Commission for charitable funds held on Trust and to the Scottish Ministers for all funds held on Trust.

17.1.2 The reserved powers of the Board and the Scheme of Delegation clarify responsibility for decisions regarding the dispersal of funds held on Board. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate Trustee.

17.1.3 The over-riding principle is that the integrity of each fund must be maintained and statutory and Board obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.4 The Finance Director shall prepare aggregated annual accounts for funds held on Trust by the Board, to be audited independently and presented to the Audit Committee annually, with the auditor invited to attend the meeting.

17.1.5 CEL (2009)40 Guidance for NHS Boards on accepting charitable donations should be adhered to.

18 RETENTION OF DOCUMENTS

18.1.1 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.

18.1.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.1.3 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.

19 STANDARDS OF BUSINESS CONDUCT

19.1 General Responsibility

19.1.1 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.

19.1.2 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.

19.2 Acceptance of Gifts and Hospitality

19.2.1 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.

19.3 Private Transactions

19.3.1 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.

19.4 Declaration of Interest

19.4.1 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.

19.4.2 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.

19.4.3 The Finance Director is responsible for putting in place arrangements for staff to declare interests. In accordance with Data Protection principles, access is strictly controlled on a need to know basis. The only department likely to be passed this information would be the Procurement Department where there may be concern about the possibility of entering into contracts with organisations which could conflict with registered interests.

Annex 1 Minimum Financial Controls
(extract from guidance on preparation of Statement of Internal Control March 2010)

Corporate Governance	
The Control Environment	
Public Finance & Accountability (Scotland) Act 2000 HDL(2003)11	Code of Corporate Governance
SSI(2001)301/2 MEL(1994)80	Standing Orders
MEL(1994)80, Annex 4 MEL(1992)35	Scheme of Reservation and Delegation
Appointed Officer Memorandum SSI(2001) 301/2	Accountable Officer Responsibilities
MEL(1994)80, MEL(1996)42 HDL(2002)25, SGHD Audit Committee Handbook	Audit Committee
HDL(2002)11, MEL(1996)42	Internal Audit function
Section 2 of the National Health Service Reform (Scotland) Act 2004 HDL(2002)11	Structures of assurance including CHPS
The Community Care (Joint Working etc.) (Scotland) Regulations 2002 CCD5/2005 CCD11/2002 Governance for Joint Services (Paper by Audit Scotland, Scottish Government & COSLA)	Partnerships including Joint Futures
Identification and Evaluation of Risks and Objectives	
HDL(2006)12 HDL(2004)46	Local Development Plan and regional planning
MEL(1994)15, MEL(1999)14, MEL(1994)80	Risk Management
Control Processes	
	Compliance with laws and regulations

Monitoring and Corrective Action	
MEL(1994)80, Annex 5	Performance reporting
MEL(1994)80, Annex 9	Policies, procedures and control frameworks
Best Value in Public Services – Secondary Guidance to Accountable Officers	Best Value
Clinical Governance	
MEL(1998)75, MEL(1998)29, MEL(2000)29, HDL(2005)41	Clinical Governance Committee
HIS Standards	Health Improvement Scotland Reports
Staff Governance	
HDL(2004)39, HDL(2005)52 Staff Governance Standard	Staff Governance Committee
HDL(2006)54, HDL(2006)23 HDL(2002)64, MEL(1994)80, Annex 1	Remuneration Committee
KSF/Agenda for Change guidance	Performance management and development
Financial Governance	
SI(1994)No. 468	Financial reporting
MEL(1994)80 NHS 1974(GEN)88	Standing Financial Instructions
MEL(1994)48 Standards Commission	Standards of Business Conduct Model Code of Conduct
HDL(2005)5 MEL(1994)48 RIPSA CEL11(2013)	Fraud Theft & Corruption Policy and Response Plan
NHS 1974(GEN)88	Budgetary control system
SI(94) No 468, MEL(1994)80, Annex 9 HDL(2001)49	Financial Procedures

MEL(1992)35 &59 ,MEL(1998)9	Acquisition, use, disposal and safeguarding of assets
MEL(1992)18 HDL(2002)87, MEL(1996)48, SCIM	Capital investment control and project management
MEL(1992)8 MEL(1992)9	Property transactions procedures Delegation of authority: land transactions
Annual Accounts Manual Capital Accounting Manual SPFM	Financial accounting and annual accounts presentation Capital accounting policy and guidance Financial policies and guidance for Scottish central government bodies
Schedule 6, part 11,section 6(1) 1990 Health Act Accountable Officer Memorandum	Arrangements to ensure resources are used effectively, efficiently and economically
Scottish Government IFRS Technical Application Notes	Application of International Financial Reporting Standards from 2009/10 and the International Financial Reporting Manual issued by HM Treasury
Health Workforce & Performance Directorate Guidance 13 March 2015	Settlement Agreements
Information Governance	
MEL(1994)64 HDL(2005)46 NHSScotland eHealth Strategy Board guidance	IM&T strategy
HDL(2006)41 MEL(1992)14 MEL(1992)45 NHS Information System Security Manual issued under MEL(1994)75	Information Security Policy
NHS Scotland Information Governance Standards	Information Governance Toolkit and annual improvement plan

THE STATE HOSPITALS BOARD FOR SCOTLAND

SCHEME OF DELEGATION

VERSION 10

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

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 Director (FD) 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
	A 4	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 covering 3 year period.
	3.1.2 & 3.1.3	FD	Submit budgets to Board and monitor performance against budget and strategic plan.
	3.2	CE	Delegate management of budgets to budget holders.
	3.3	FD	Devise and maintain systems of budgetary control.
	3.3	FD	Deliver adequate training on an ongoing basis to budget holders to enable them to manage effectively.
	3.4	CE	Identifying and implementing cost improvements and income generation initiatives.
	3.6	CE	Ensuring that the required financial performance returns are submitted to the SGHSCD.
	4	FD	Prepare annual accounts, financial returns and supporting papers
	5.1	FD	Managing the Board's banking arrangements
	6.1	FD	Designing, maintaining and ensuring compliance with income systems.
	7.1	CE	Capital programme investment process, and scheme of delegation for capital investment management.
	7.1.4	FD	Procedures for the regular reporting of expenditure and commitment, including reporting to the Board.
	7.1.9	FD	Procedures for financial management of capital investment.

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

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

	SFI Reference	Delegated to	Duties Delegated
	16.1.8	FD	Preparing an abstract of receipts and payments for patients' funds, for presentation to the Audit Committee annually; with independent audit.
	17	FD	Preparing aggregated annual accounts for funds held on Trust by the Board; with independent audit.
	18.1.1	CE	Retention of document procedures.
	19.1	CE	Standards of Business Conduct policy.
	19.2	FD	Maintain a Register of Gifts and Hospitality.
	19.4	CE	Maintain Register of Board members interests
	19.4	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 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	Involvement & Equality 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	N/A	N/A	CG & RM standards
4.4 Service Level Agreements with other Health Boards	Chief Executive	Finance Director	all	CG & RM standards
4.5 Partnership Agreements	Chief Executive	N/A	all	

5. Risk Management

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
5.1 Preparation of Risk Management Strategy	Chief Executive	Finance Director	N/A	CG & RM standards Statement of Internal Control
5.2 Policies and Procedures				
Risk Management	Finance Director	Risk Manager	N/A	CG & RM standards
Child Protection	Director of Nursing & AHP	N/A	N/A	
Prescribing	Associate Medical Director	N/A	N/A	HDL(2007)12 Safer management of controlled drugs - Accountable Officer status delegated to Associate Medical Director
Health and Safety	Chief Executive	Finance 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	Risk Manager	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	Equality & Involvement Lead	N/A	
Volunteering	Director of Nursing & AHP	Equality & Involvement Lead	N/A	
Spiritual and Pastoral Care	Director of Nursing & AHP	Equality & Involvement Lead	N/A	
Patient and Carer Information and Communications	Director of Nursing & AHP	Equality & Involvement 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	Director of Nursing & AHP	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	N/A	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	Head of Management Accounts	Allocation Letter	
13.3 Preparation of budgets	Finance Director	Head of Management Accounts	Per Financial Plan	
13.4 Financial Systems and Operating Procedures	Finance Director	Head of Financial Accounts	N/A	
13.5 Financial Performance Reporting System	Finance Director	Head of Financial Accounts	N/A	
13.6 Maintenance / Operation of Bank Accounts	Finance Director	Head of Financial Accounts	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	Head of Financial Accounts	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	Head of Management Accounts		
d) achievement of savings	Directors Chief Executive	Named Deputies	Savings notified	

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

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
d) Extensions to existing leases	Chief Executive and Finance Director jointly	N/A	N/A	
e) Letting of premises to outside organisations	Chief Executive	N/A	N/A	
f) Approval of rent based on professional assessment	Finance Director	N/A	N/A	
14.7 Non-Pay Revenue Expenditure - Requisitioning/				
Ordering of Goods and Services				
a) Value over £100,000	Board	N/A	>£100k	
b) Annual Value over £20,000 and up to £100,000	Chief Executive	Finance Director, Deputy Chief Exec	>£20k < £100k	Subject to containment within overall Board resources
	Procurement Manager (PO only)	Procurement Team Leader, Head of Financial Accounts, Finance Director (PO only)		
c) Annual Value over £4,000 and up to £20,000	Finance Director	Chief Exec, Deputy Chief Exec	>£4k < £20k	Subject to containment within overall Board resources
	Procurement Manager (PO only)	Procurement Team Leader, Head of Financial Accounts, Finance Director (PO only)		

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
d) Annual Value over £2,400 and up to £4,000	Budget Director	Finance Director, Chief Exec, Deputy Chief Exec	>£2.4k < £4k	Subject to containment within overall delegated funds for Directorate
	Procurement Manager (PO only)	Procurement Team Leader, Head of Financial Accounts, Finance Director (PO only)		
e) Annual Value over £1,000 and up to £2,400	Budget Manager	Budget Director	>£1k < £2.4k	Subject to containment within overall delegated funds for budget manager
	Procurement Manager (PO only)	Procurement Team Leader, Head of Financial Accounts (PO only)		
f) Annual Value up to £1,000	Budget holder	Budget Manager	<£1k	Subject to containment within overall delegated funds for budget holder
	Procurement Manager (PO only)	Procurement Team Leader (PO only)		
		Head of Financial Accounts (PO only)		
g) 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
h) Orders exceeding a 12 month period and up to £50,000	Finance Director	Chief Executive	< £50k	Subject to containment within overall Board resources
i) Subsequent variations to contracts	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

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
- Laundry - up to £4,000	Estates Manager	Estates Co-ordinator		
- Decontamination – up to £3,000	Estates Manager	Estates Co-ordinator		
- Shop Trading Account – up to £4,000	Designated budget holders	N/A	< £4k	Countersigned by Procurement Manager (PO only)
l) Consolidated orders up to £10,000	Procurement Manager	Procurement Team Leader	< £10k	Subject to individual items authorised as above
m) Invoice matching queries	Procurement Manager / Head of Financial Accounts	Assistant 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 £ 2,400	Security Director	N/A	<£0.0018	
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 £24,000	Finance Director	N/A		
- value up to £4,000	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	or 10% of approved spend whichever is lower

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.9 Quotation, Tendering and Contract Procedures				
a) Quotations Three minimum quotations for goods/services for spend over £5,000 and up to £10,000	Procurement Manager	N/A	>£5k < £10k	refer to tendering procedures
b) Tenders Three minimum quotations for goods/services for spend over £10,000 and up to £100,000	Finance Director	N/A	>£10k < £100k	refer to tendering procedures
Three minimum quotations for goods/services for spend over £100,000	Chief Executive	N/A	>£100k	subject to EU regulations
c) Waiving of quotations & tenders subject to SOs	Chief Executive & Finance Director	N/A	N/A	
d) Arrangements for opening tenders	Procurement Manager	N/A	N/A	

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.10 Condemning & Disposal of Assets (excluding heritable property) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively				
- with current /estimated purchase price up to £50,000	Finance Director	Head of Financial Accounts	< £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	Head of Financial Accounts	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	

STATE HOSPITALS BOARD FOR SCOTLAND

STANDING ORDERS

Version 13

Version Control Log		
Version	**Date**	**Description**
7	24 Nov 2008	Section 24 includes reference to the Board putting in place a Hospitality Policy. This is currently in draft and will be provided to the Audit Committee in January 09 for approval. Section 26 updated to reflect change in approval mechanism of Committee minutes. Paragraph 27 clarification of ex-officio status. This is also reflected in the terms of reference of committees.
7.1	15 Jan 2009	Amended for Board comments
7.2	19 April 2012	
8	30 April 2013	Amended for Audit Committee comments
8.1	June 2013	Approved by Board June 2013
9	April 2014	Paragraph 20b amended to reflect reference to 20(a) (changed from 21(a). Paragraph D27e amended as per Audit Committee on 24 April 2014. Approved by Board 26 June 2014
10	April 2015	Approved by Audit Committee 2 April 2015 after following changes made: Paragraph B9(a) amended to reflect Board meets every second month.

		Paragraph B12© amended to remove reference to Sub Committee. Paragraph B12(e) amended in respect of meetings being quorate as per their Terms of Reference.
11	March 2016	Section 5 – added sentence re annual confirmation of Declaration of Interests. Section 20(a) – amended limits for disposal of assets from £25,000 to £50,000 to agree with SFI's.
12	March 2017	Approved by Audit Committee 23 March 2017 Approved by Board 4 May 2017
13	March 2018	Approved by Audit Committee 5 April 2018

FOREWORD

Standing Orders, together with Standing Financial Instructions, provide a regular framework for the business conduct of the Board. They fulfil the dual role of protecting the Board's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegations and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

Failure to comply with standing orders and standing financial instructions is a disciplinary matter which could result in dismissal.

STANDING ORDERS

For regulating the business and proceedings of the State Hospitals Board for Scotland, and its Committees made under the terms of the Health Boards (Membership and Procedure) (No 2) Regulations 1991 (S.I. 1991 No.809 (S74)), and the mandatory elements of NHS Circular MEL (1994) 80.

The Standing Orders of the Board shall apply, where applicable, to all Committees and Sub-Committees of the Board.

The Ethical Standards in Public Life etc. (Scotland) Act 2000 introduced a Members' Model Code of Conduct and the Board adopted the Code in July 2002.

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.

B MEETINGS OF THE BOARD AND COMMITTEES

8 General

a) The Chief Executive shall cause notices of all meetings of the Board and Committees, together with a note of the agenda and of any Committee minutes and reports which are to be submitted to such meetings, to be delivered or sent by post so as to reach each Member of the Board five clear days before the date of the meeting. Failure of delivery of any notice shall not invalidate the proceedings of the meeting to which the notice refers.

b) At every meeting of the Board the Chairperson, if present, shall preside.

9 Ordinary Meetings of the Board

a) The ordinary meetings of the Board shall, unless the Board otherwise agrees, be held on the third Thursday of every second month at the State Hospital, Carstairs or at such place and at such time as the Board shall determine.

b) No business shall be transacted at ordinary meetings of the Board other than that specified in the agenda unless it has been notified to the Chairperson prior to the meeting and has the consent of the majority of the Members of the Board present.

10 Special Meetings of the Board

a) The Chairperson may call a special meeting of the Board at any time as required, or on receiving a requisition in writing for that purpose signed by one third of the whole number of Members of the Board (including at least two non-executive Members), of which meeting at least three clear days notice shall be given and specifying the business proposed to be transacted at the meeting. Such meetings shall be held within fourteen days of receipt of the requisition.

b) No business shall be transacted at a special meeting of the Board other than that specified in the requisition.

11 Annual Presentation of Accounts

At the appropriate Public Board Meeting, normally June, the Board shall present its annual report, audited accounts and any report on these accounts by the appointed auditor.

12 Quorum

No business shall be transacted at a meeting of the Board unless at least one third of the whole number of Members of the Board is present; of whom a majority should be non-executive Members.

If within thirty minutes after the time appointed for the meeting, a quorum of members is not present, the meeting shall stand adjourned, and the Chief Executive will arrange for it to be minuted that, owing to the want of the necessary quorum, no business was transacted.

An ordinary meeting shall be held to be adjourned until the next ordinary meeting unless otherwise stated and at that meeting the business left over at the adjourned meeting shall be entitled to preference over other business.

A special meeting standing adjourned shall be held to be adjourned *sine die.*

The proceedings at meetings of the Board or its committees shall not be invalidated by any vacancy in its membership or by any defect in the appointment of any member thereof.

13 Notice of Motion and Order of Debate

a) A motion which is contradictory to a resolution of the Board shall not be competent within six months of the date of adoption of such resolution unless:

i) the consent of two thirds of the Members of the Board present and voting be obtained; or

ii) notice of the motion, having been signed by at least one-third of the whole number of Board Members, shall be given to the Chief Executive at least fourteen days in advance of the meeting, and shall be specified in the circular calling the meeting. All Board Members shall be notified at least seven days in advance of the meeting of the inclusion of the motion in the circular; or

iii) in the case of emergency (involving such matters as a substantial change of circumstances, an illegality, a miscarriage of justice, a breach of ethics or the like).

b) Any motion or amendment shall, if required by the Chairperson of the meeting, be reduced to writing, and after being seconded shall not be withdrawn without the leave of the Board and Committee. No motion or amendment shall be spoken upon except by the mover until it has been seconded.

c) No member shall have the right to speak more than once on any motion or amendment except on a point of order in explanation of some material part of his/her speech which he/she believes to have been misunderstood.

d) A member formally seconding a motion or amendment will be deemed to have spoken in the debate.

e) The mover of any original motion shall have the right to reply. In replying he/she shall not introduce new matter and shall be confined strictly to answering observations made in debate. Immediately after, the Chairperson of the meeting shall put the question without further debate.

f) When an amendment upon an original motion has been moved and seconded, no further amendment may be moved until the previous one has been disposed of. If an amendment be rejected, other amendments may be moved on the original motion. If an amendment be carried, the motion as amended shall take the place of the original motion and shall become the question upon which further amendments may be moved.

g) The duration of speeches may, unless otherwise determined by a simple majority of Members present and voting, be limited by the Chairperson of the meeting to ten minutes for the mover, five minutes for the seconder and three minutes for other speakers.

h) The ruling of the Chairperson of the meeting on all points of order and on the order of debate shall be final. Members should address the chair. The Chairperson shall call upon Members to speak.

14 Closure of Debate or Adjournment

A motion of adjournment of any meeting of the Board or Committee; or adjournment of any debate on any question, or the closure of the debate shall be put to the meeting after being seconded, without discussion. Unless the time and place are specified in the motion for adjournment, the adjournment shall be until the next ordinary meeting of the Board and the Committee.

15 Voting

a) If it be so decided by not less than one third of the members attending a meeting on act of or question, coming or arising before, a meeting of the Board or a Committee shall be done and decided by a majority of the Members present and voting at the meeting and, in the case of an equality of votes, the person presiding at the meeting shall, in addition to his/her deliberate vote, have a casting vote.

b) The number of votes cast for and against motions and amendments shall be recorded in the minutes.

16 Emergency Powers of Chairperson

The Chairperson is empowered to act for the Board between meetings of the Board in emergency situations of a financial nature not covered by the Board's scheme of financial delegation.

Such action will be reported to the Board at the next meeting.

17 Delegations and Deputations

a) Any individual or organisation wishing to make representation to the Board will be heard if:

i) a written application setting forth the subject matter on which a hearing is requested has been lodged with the Chief Executive at least 21 days in advance of the Board Meeting which the delegation wishes to address, and

ii) the Chairperson has considered the request and has agreed to recommend that the delegation or deputation should attend the Board Meeting.

b) When a delegation or deputation is received by the Board, Members may put to the delegation or deputation pertinent questions, but no Members shall express an opinion upon or discuss the subject matter until the delegation has withdrawn from the Board meeting.

c) The terms of Standing Orders apply to delegations and deputations.

18 Communications with the Press & Public

No communication on behalf of the Board shall be made to the Press & Public except through the Chief Executive, Directors and the Head of Communications. Meetings of the Board are open to the Press and the Public. Meetings of the Sub-Committees are not open to the Press and Public.

19 Suspension and Disqualification of Members

Any member disregarding the authority of the Chairperson or who obstructs the meeting or conducts himself/herself offensively shall be suspended for the remainder of the meeting if a motion (which shall be determined without discussion) for his/her suspension is carried. Any person so suspended shall forthwith leave the meeting and shall not, without the consent of the meeting, return. If a person so suspended refuses, when required by the Chairperson to leave the meeting, he/she may immediately be removed from the meeting by any person authorised by the Chairperson so to do.

20 Scheme of Delegation

The Board will reserve certain decisions to itself and will delegate all other decisions to the Directors, through the Chief Executive. Any changes to the Scheme of Delegation will be made with prior agreement of the Board.

a) Matters on which decisions on, and/or approval of, are retained by the Board or authorised Committee or Sub-Committee;

* Strategy, business plans and budgets;
* Standing Orders;
* Standing Financial Instructions;
* appointment of Chief Executive and any Director;
* the establishment, terms of reference and reporting arrangements for all Committees and Sub-Committees;
* capital expenditure plans exceeding £25,000;
* disposal of assets exceeding £50,000;
* recommendations from all Committees and Sub-Committees (where powers are not delegated);
* Annual Report and Annual Accounts;
* financial and performance reporting arrangements;
* financial audit arrangements
* security audit arrangements.

b) All other decisions:

* all decisions, other than those included in paragraph 20 (a), are delegated (as detailed in the Standing Financial Instructions) to senior management through the Chief Executive and include the undernoted matters:
  - issuing, receiving and opening of tenders;
  - delegation of budgets and approval to spend funds;
  - operation of all detailed financial matters including bank accounts and banking procedures;
  - management of non-exchequer funds;
  - arrangements for the management of land, buildings and other assets belonging to or leased by the Board;
  - management and control of computer systems and facilities;
  - recording and monitoring of payments for losses and compensation ;
  - making ex-gratia payments (up to a maximum of £25,000);
  - health and safety arrangements;
  - data protection arrangements.
* authorisation limits related to the scheme of delegation and, where indicated, details of the officers who have been delegated responsibility, are included within the Standing Financial Instructions.

21 Annual Report

The Board will publish an Annual Report on its performance.

The Report will be prepared in accordance with the requirements set out from time to time by the Scottish Government on behalf of the First Minister and will include, interalia, details of remuneration from NHS sources paid to Members of the Board and matters related to the Patients Charter.

22 Annual Accounts

The Board will produce a set of Annual Accounts in accordance with the requirements set out by the Scottish Government on behalf of the First Minister.

23 Standards of Business Conduct for Staff

The Board will incorporate in its Terms and Conditions of Employment, a code of business conduct, which will include guidance issued from time to time by the Scottish Government and the Board will ensure that this is drawn to the attention of all staff and directly employed contractors. Additionally, the Board will put in place a policy for the management of Hospitality and compliance with this policy will be monitored by the Audit Committee.

C MINUTES

24 Recording of Names of Members Present

The names of Members present at a meeting of the Board or of a Committee of the Board shall be recorded in the minutes. Where a Member is not present for the whole of a meeting this shall also be recorded.

25 Preparation, Approval and Distribution of Board and Committee Minutes

a) Minutes of the proceedings of a meeting of the Board shall be drawn up by, or on behalf of the Chief Executive and shall be circulated to members in draft form within ten days. The minutes shall be submitted to the next ensuing meeting of the Board for approval as a record of the meeting and signed by the person presiding at that next ensuing meeting.

b) Minutes of the proceedings of a meeting of Committee shall be drawn up by, or on behalf of, the Chief Executive and submitted for approval to the Board at the first ordinary meeting of the Board held after the meeting of the Committee.

c) Copies of the approved minutes of every meeting of the Board shall be forwarded to the Scottish Government by the Chief Executive not later than one week before the date of the next Board meeting.

D COMMITTEES

26 Chairperson and Chief Executive

The Chairperson of the Board, and the Chief Executive, shall both be members, ex-officio of all Committees with the exception of the Audit Committee and the Committees whose constitution is determined by Statute. An ex-officio member is a member of a body (a board, committee, etc.) who is part of it by virtue of holding another office. Depending on the Committee terms of reference, such a member may or may not have the power to vote in the Committee's decisions.

27 Appointment of Committees

a) The Board may, and if so directed by the First Minister shall, appoint Committees and Sub-Committees or other groups, for such purposes as they may determine, subject to such restrictions or conditions as the Board may think fit, or as the First Minister may direct.

b) Standing Committees shall be appointed annually by the Board in the month of April each year. Casual vacancies in the Committees may be filled by the Board at their next ordinary meeting following a vacancy occurring.

c) The Board shall appoint among any such standing Committees a Clinical Governance Committee, a Staff Governance Committee, an Audit (Finance) Committee and a Remuneration Committee.

d) Committees of the Board may appoint Sub-Committees as may be considered necessary.

e) No business shall be transacted at a meeting of a Committee or Sub-Committee of the Board unless the meeting is quorate as defined in the Committee's individual Terms of Reference.

E COMMON SEAL

28 The Common Seal of the Board shall be kept by the Chief Executive in a suitable place secured by a sufficient lock and he/she shall be responsible for its safe custody and its use. All deeds and other documents to which the common seal shall require to be affixed shall be attested by a Member of the Board and by the Chief Executive who shall maintain a register of use. (The Board has approved the Chief Executive as the person acting as "Secretary" for the purpose of the application of the Board Common Seal, to accord with the terms of the National Health Service (Scotland) Act 1978, Schedule I, part I Paragraph 9).

F SUSPENSION AND ALTERATION OF STANDING ORDERS

29 Suspension of Standing Orders

Any Standing Order may be suspended with the consent of two thirds of the Members present and voting.

30 Rescinding or Alteration of Standing Orders

It shall only be competent to rescind or alter any of the Standing Orders by resolutions of the Board to that effect.

31 Review of Standing Orders

The Board shall review Standing Orders from time to time and shall make any new Standing Order or alteration to any existing Standing Order which may seem to be required for the better conduct of the business of the Board, or as the First Minister may direct.

G BREACH OF STANDING ORDERS

32 The Chief Executive or his/her appointee will draw to the attention of the Chairperson of a meeting any apparent breach of the terms of these Standing Orders.

H INTERPRETATION

33 Unless the context determines otherwise the masculine includes the feminine, the singular the plural, the Committee the Sub-Committee, etc.

I STANDING FINANCIAL INSTRUCTIONS

34 The Board's approved Standing Financial Instructions will form part of these Standing Orders.

ANNEX A

SANCTIONS AVAILABLE TO THE STANDARDS COMMISSION FOR BREACH OF THE CODE

(a) censure – the Commission may reprimand the member but otherwise take no action against them;

(b) suspension – of the member for a maximum period of one year from attending one or more, but not all, of the following:

i) all meetings of the State Hospitals Board for Scotland;

ii) all meetings of one or more committees or sub-committees of the State Hospitals Board for Scotland;

iii) all meetings of any other public body on which that member is a representative or nominee of the public body of which they are a member.

(c) suspension – for a period not exceeding one year, of the member's entitlement to attend all of the meetings referred to in (b) above;

(d) disqualification – removing the member from membership of the State Hospitals Board for Scotland for a period of no more than five years.

Where a member has been suspended, the Standards Commission may direct that any remuneration or allowance received from membership of the State Hospitals Board for Scotland be reduced, or not paid.

Where the Standards Commission disqualifies a member of the State Hospitals Board for Scotland, it may go on to impose the following further sanctions:

(a) where the member of the State Hospitals Board for Scotland is also a councillor, the Standards Commission may disqualify that member (for a period of no more than five years) from being nominated for election as, or from being elected, a councillor. Disqualification of a councillor has the effect of disqualifying that member from the State Hospitals Board for Scotland and terminating membership of any committee, sub-committee, joint committee, joint board or any other body on which that member sits as a representative of their local authority.

(b) direct that the member be removed from membership, and disqualified in respect of membership, of any other devolved public body (provided the Members' Code applicable to that body is then in force).

Full details of the sanctions are set out in Section 19 of the Act.

ANNEX B

DEFINITIONS

"Remuneration" includes any salary, wage, share of profits, fee, expenses, other monetary benefit or benefit in kind. This would include, for example, the provision of a company car or travelling expenses by an employer.

"Undertaking" means: a body corporate or partnership; or an unincorporated association carrying on a trade or business, with or without a view to a profit.

"Related Undertaking" is a parent or subsidiary company of a principal undertaking of which you are also a director. You will receive remuneration for the principal undertaking though you will not receive remuneration as director of the related undertaking.

"Parent Undertaking" is an undertaking in relation to another undertaking, a subsidiary undertaking, if a) it holds a majority of the voting rights in the undertaking; or b) it is a member of the undertaking and has the right to appoint or remove a majority of its board of directors; or c) it has the right to exercise a dominant influence over the undertaking (i) by virtue of provisions contained in the undertaking's memorandum or articles or (ii) by virtue of a control contract; or d) it is a councillor of the undertaking and controls alone, pursuant to an agreement with other shareholders or councillors, a majority of the voting rights in the undertaking**.**

Group of companies" has the same meaning as "group" in section 262(1) of the Companies Act 1985. A "group", within s262 (1) of the Companies Act 1985, means a parent undertaking and its subsidiary undertakings.

"Public body" means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000.

"A person" means a single individual or legal person and includes a group of companies.

"Any person" includes individuals, incorporated and unincorporated bodies, trade unions, charities and voluntary organisations.

"Spouse" does not include a former spouse or a spouse who is living separately and apart from you.

"Cohabitee" includes a person, whether of the opposite sex or not, who is living with you in a relationship similar to that of husband and wife.

"Chair" includes Board Convener or any person discharging similar functions under alternative decision-making structures.

Board Paper 18/21

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 April 2018
Agenda Reference:	Item No: 18
Sponsoring Director:	Finance & Performance Management Director
Author(s):	Head of Financial Accounts
Title of Report:	Project Bank Accounts
Purpose of Report:	For review and approval

1 SITUATION

This paper is provided to the Board to request approval for opening a Project Bank Account in respect of the Security Upgrade project for which the costs fall within the provisions for implementing as per the Scottish Public Finance Manual (SPFM).

2 BACKGROUND

Scottish Government issued guidance that Project Bank Accounts (PBAs) be set up for construction contracts for Scottish Government and relevant bodies in scope of the SPFM where the estimated award value is at least £4,104,394 for building projects and £10,000,000 for civil engineering projects.

The Security Upgrade being funded from capital is regarded as a building project which is estimated at a cost of £7,180,000 and falls into the requirement to have a Project Bank Account set up.

3 ASSESSMENT

The Project Bank Account requires to be set up jointly in the name of The State Hospital and the main contractor. The tender documents must indicate that this is a requirement and banking forms will be required to be completed by the relevant bidders.

A meeting is arranged with the Royal Bank of Scotland to take this forward and get the account set up.

The authorisation of payments will be made by nominated individuals within the hospital and the main contractor's business and will be jointly authorised.

4 RECOMMENDATION

The Board is asked to approve the implementation of opening a new bank account for Projects.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Ensures that the Board complies with Scottish Government guidance.
Workforce Implications	None
Financial Implications	Additional bank charges will be incurred.
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Paper prepared by Head of Financial Accounts and reviewed by Finance & Performance Management Director
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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Audit Committee held on Thursday 18 January 2018 at 9.45am in the Boardroom, The State Hospital, Carstairs.

PRESENT:

Non Executive Director	Bill Brackenridge
Non Executive Director	Elizabeth Carmichael **[Chair]**

IN ATTENDANCE:

Internal

Chief Executive	Jim Crichton
Board Chair	Terry Currie
Security Director	Doug Irwin [For Minute 5]
Employee Director	Anne Gillan
Finance and Performance Management Director	Robin McNaught
Nurse and AHP Director	Mark Richards
Board Secretary	Margaret Smith
Deputy Security Director	Nicola Watt [For Minute 5]
Interim HR Director	John White [For Minute 6]

External

Senior Manager, RSMUK	Asam Hussain
Director, Scott-Moncrieff	Karen Jones
Head of Internal Audit, RSMUK	Mark Mazzucco

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Apologies for absence were noted from Maire Whitehead.

NOTED

2 CONFLICTS OF INTEREST

There were no changes to the conflicts of interest noted at the last meeting. All conflicts declared would be held on record for the year. Any changes would be reported and recorded as they arose.

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on Thursday 14 September 2017 were approved. The Minutes were submitted in draft to the Board Meeting for noting on 14 December 2017.

NOTED

4 MATTERS ARISING AND ACTION NOTES UPDATE

Members received and noted the Summary Action Points, and the progress made. It was noted that the Draft Audit Committee Workplan 2018 had been updated and that this item would be closed.

An update on the Effective Rostering and Overtime Management Report would be submitted to this meeting, following the update provided to the Board in October 2017. An update in relation to the General Data Protection Regulation (GDPR) would be presented to this Committee in April 2018. The Audit Committee Effectiveness Self –Assessment checklist would be circulated, and this item could then be closed.

NOTED

5 ANNUAL UPDATE ON STATE HOSPITAL RESILIENCE ARRANGEMENTS

The Committee was asked to note a report from the Security Director which provided Members with an annual update on State Hospital Resilience Arrangements.

Ms Watt was also in attendance and led Members through the report, highlighting the key issues. The report presented the background to emergency and resilience planning for The State Hospital (TSH) as well as outlining the relationships between local and national resilience forums.

Resilience arrangements were covered by four key documents and there had been no requirement for significant change to these over the past year. The Resilience Committee Action Plan had been reviewed and updated with progress made, and it was noted that the Loss of the Control Room Plan has been approved. The Procurement Plan would be reviewed for approval as a matter of priority. The Loss of Staff Plan was under review.

Ms Watt highlighted that there were no Level 3 incidents in the past year, and Level 2 incidents have been reviewed for lessons learned. She detailed the progress made in relation to training in the past year. She advised the Committee that the work led by Scottish Government in regard to national NHS Standards for Organisational Resilience was continuing, with the expectation that revised standards would be published in spring 2018. Finally, she outlined the key priorities for 2018.

Ms Carmichael noted the comprehensive nature of the report, and opened discussion. Bill Brackenridge sought further assurance in relation to Section 7 of the report, particularly in terms of compliance with NHS Scotland standards. Ms Watt provided further clarification that these would only apply in part to TSH as it was not a Category 1 / 2 responder, however, further work was required in this area particularly in regard to eHealth. In response to a further question from Mr Brackenridge, she explained that the three Duty Directors were trained Incident Commanders with an on call rota in place. A further twenty members of staff [Senior Charge Nurses and Security Managers] had received Golden Hour training which then provided appropriate contingency planning until the a Duty Director came on site. Mr Crichton further clarified that during Monday to Friday a Director would be on site, or able to be on site, in less than an hour through normal working hours of 9am to 5pm.

Ms Gillan asked about progress made on Negotiator training given the numbers of trained negotiators coming to retirement age, and it was confirmed that progress was continuing in line with the Action Plan.

Mr Currie asked whether there was any discernable trend in the number of Level 2 incidents, year on year and there was further discussion around the table regarding revision of Section 4 of the report to give historical perspective on both Level 2 and Level 3 incidents. Ms Watt confirmed that she would review the figures and provide a further update for the Committee.

Action: Nicola Watt/ Doug Irwin

Mr Hussain noted the pressures indicated within IT and highlighted this as an area that required concerted attention. Mr Irwin explained the background of legacy issues and Mr McNaught provided an update with regard to current staffing issues within eHealth. Mr Crichton acknowledged that eHealth was a potential area of concern for resilience particularly as it was an area of constantly changing demand and this should be viewed within a long term national problem

of recruitment. This would require strategic thinking over the longer term to build resilience at regional and national levels, whilst requiring operational management in the shorter term.

The Committee noted the report, with a request that future reporting should include trend analysis in relation to incidents reporting.

The Committee noted the priorities set out in the report for 2018, in particular the training requirements for a changing workforce and the issues highlighted for eHealth. The Committee noted the importance of resilience arrangement for TSH and thanked the Resilience Committee for their work in this area.

NOTED

6 ATTENDANCE MANAGEMENT UPDATE

The Committee was asked to note a report from the Interim Director for Human Resources which provided a quarterly update on attendance at TSH, and placed this within a national context. Mr White summarised the report for Members, which detailed improvements on the key indicators. He drew attention to the additional report provided which outlined the Attendance Management Improvement Plan for TSH.

Ms Carmichael noted the assurance provided within the report on current trends in attendance. The report provided clear presentation of the relevant data which allowed focus on problem areas. She noted that significant improvement made in nursing staff attendance, and queried the impact of this to the overall workforce figure. Mr White clarified that whilst nursing attendance had improved, there had unfortunately been decreases in attendance form other cohorts within the workforce, especially housekeeping and administration.

There was further discussion around the significance of the data with 50 Whole Time Equivalent (WTE) absent at any one time and the loss of this resource for TSH in terms of delivery of care. Members agreed that the trend had moved in the right direction, albeit slowly.

Mr Currie asked for further detail on the split between short term and long term sickness rates and how work was focussed towards reducing each. Mr White provided further detail on how support was directed for staff on long-term absence in conjunction with partners so that appropriate consideration could be given on each individual case. There was concerted focus on reducing short term absence through a variety of means including EASY.

Members noted the performance target and action plan outlined in the 12 week improvement plan which had been commissioned by the Staff Governance Committee and developed by Senior Management alongside the Partnership Forum.

Ms Gillan confirmed that staff side were supportive in this regard, and added the point that an aging nature of the workforce overall should be considered in terms of the effect this could have over the longer term. Mr Brackenridge noted that improvement in staff absence rates would have a positive impact on the workforce as a whole, in terms of service provision. Mr Crichton emphasised the systematic approach put in place, to assist in identifying patterns within absence and the benefits of this approach would be seen over time.

The Committee noted that report and that although staff absence rates remain an issue, good progress had been made and the work undertaken had begun to have an impact with the figures for November 2017 providing assurance of this. Further, that differing methods were being utilised to prioritise reduction of short term absence, with this being extended to long term absences as appropriate; and that the intention was that the reduction in nursing staff absence would in time extend to the workforce as a whole.

NOTED

7 EFFECTIVE ROSTERING & OVERTIME AUDIT UPDATE AND ACTION PLAN

The Committee was asked to note a report from the Director of Nursing and AHP, which provided an update on actions taken following the effective rostering and overtime audit undertaken by RSM as internal auditors, and which reported in August 2017. Ms Carmichael confirmed that the Audit Committee had requested an update on progress made given the urgency required.

Mr Richards provided Members with an overview of the key actions taken, and the progress made. In particular, he highlighted the use of SSTS as a platform to record the reasons for use of overtime, as well as streamlining the process for creating rosters, introduction of a protocol for shift swaps. He emphasised that management had undertaken review of overtime processes with confirmation of overtime worked moved to Senior Charge Nurse (SCN) responsibility at ward level to ensure local accountability. A system was in place to monitor variance from the overtime limit protocol. A weekly report was put in place to measure weekly variance from overtime budget, and this was to be reported and monitored by Mr Richards in conjunction with Mr Crichton.

Mr Richards asked Members to note that although some protocols were reported as requiring approval from the Partnership Forum, discussions and already taken place with a view to enabling this.

In answer to a question from Ms Carmichael on the measurement of the impact of the action taken on rostering, Mr Richards described the system of management controls put in place which made best use of the support systems available (e.g. SSTS) to simplify the process overall as well as removing duplication all of which led to more effective decision-making. In particular, he conducted quarterly meetings attended by the Clinical Operations Manager, Lead Nurses and SCNs to ensure direct oversight of both the process and the decisions made at local and senior level.

Members agreed that the report provided a good update on the actions taken and discussion around the table centred upon how and when change leading on from these actions would lead to concrete, clearly evidenced change as well as the nature of the benefits accrued. Mr Richards advised that this report evidenced the good governance put in place, meaning that systems could be better interrogated; at the same time further consideration would be required to analyse the underlying trends and the strategic impact of significant trends identified with a view to reducing overtime. At the same time it may not be possible to assume a direct link between effective rostering and use of overtime, given other factors at play.

Mr Currie emphasised the need for further audit over time, so that this analysis could be facilitated and greater consideration given to all of the issues.

Mr Hussain asked whether it would be of benefit to hold the quarterly meeting with key management and nursing colleagues on a monthly rather than quarterly basis. Mr Richards described the nature of staff engagement, at weekly and monthly interval already in place with the quarterly meeting to oversee this process and that this was working effectively.

Ms Carmichael commended the usefulness of this report in providing a timely update for the Committee and noted the additional work being undertaken in this context by the Board. Mr Richards reported that following on from the audit recommendations, senior management had honed in these in three stages: processes in terms of information systems and assurance, scope for review of the operating model through external challenge as well as through the existing decision-making model. Though this was clinically driven as appropriate, there had been challenge to the robustness of the process without transgressing into overriding clinical responsibility. This was received positively by Members who were content to note the report. The Committee requested an update report for the next meeting to include detail on the impact found after the first six months, as well as external consultative work undertaken.

Action: Mark Richards

NOTED

8 FRAUD ACTION PLAN

The Committee was asked to note a report from the Director of Finance and Performance Management which provided an update on the Board's approach to countering fraud. He led Members through the report highlighting the measures undertaken.

Members noted the update on the approach taken within TSH.

NOTED

9 FRAUD UPDATE

The Committee was asked to note a report from the Director of Finance and Performance Management which provided an update on fraud allegations and notifications received from Counter Fraud Services.

Mr Mazzucco advised that in relation to the Phishing Email Review, RSMUK could provide support in identifying scamming and it was agreed that this could link into the review of eHealth. It was also agreed that it would be helpful for the Committee to receive more detail regarding the outcome of items recorded and cleared on the Incident (Fraud) Log, as well as further detail on progress of investigation on outstanding items.

Action: Robin McNaught

NOTED

10 CORPORATE RISK REGISTER UPDATE

The Committee was asked to note a report from the Director of Finance and Performance Management on the Corporate Risk Register which provided an update and asked the Committee to decide which (if any) of the proposed new risks should be included on the Corporate Risk Register. It was noted that this would be subject to full review in the Audit Committee workshop to take place immediately after this meeting.

NOTED

11 INTERNAL AUDIT PROGRESS REPORT

Following approval of the Internal Audit Plan 2017/18 by the Audit Committee at its meeting held on 29 June 2017, RSMUK submitted a summary update on progress made against that plan and a summary of the results of their work to date.

Mr Hussain provided Members with an overview, noting the positive findings contributing to the annual Head of Internal Audit Opinion for 2017/18. It was noted that two reports had been finalised; Complaints and Patient Funds and that the findings of each would follow this report in being presented to the Committee. It was confirmed that no property transactions have been undertaken by TSH during the period under review.

The new format of the Tracking Report was met positively by Members and following discussion it was agreed that this format should be adopted going forward, subject to addition of an internal assessment from Mr McNaught in each report as well as a note of the External Auditor's recommendations.

Action: RSMUK/Robin McNaught

NOTED

12 COMPLAINTS SYSTEM AUDIT REPORT

A report was submitted by RSMUK in relation to an audit of the new complaints system as part of the approved internal audit plan for 2017/18.

The report concluded that THS had a detailed policy and procedure for complaints and this was in accordance with the guidance issued by the SPSO. Some key areas had been identified for improvement including lessons learnt through the investigation of complaints - accurate recording of the date of receipt of the complaint and trigger of investigative period and clearly recording the complainant's preferred method of communication. Mr McNaught reported that strong progress had been made in line with these recommendations.

During discussion, it was clarified that should senior management disgree with any recommendation; this would be highlighted by RSMUK during reporting. This had not been the case in this instance.

The Committee noted the report, including the recommendations and timescales for improvements to be met. A copy of the report would be made available to the Chair of the Clinical Governance Committee.

Action: Margaret Smith

NOTED

13 PATIENT FUNDS AUDIT REPORT

A report was submitted by RSMUK which focused on the controls in place to ensure that patient funds were managed in line with the Board's Patient Funds Policy. The report reported positively that adequate controls were in place to ensure that patient funds were properly receipted, issued and managed in such a manner to allow patients as much access to their funds as possible.

NOTED

14 EXTERNAL AUDIT PLAN

A report was submitted by Scott-Moncrieff Chartered Accountants which summarised the work plan for the 2017/18 external audit of TSH.

Ms Jones was in attendance and provided an overview for Members. She highlighted an area of significant audit risk in particular being the loss of financial expertise with the coming retirement of the Head of Financial Accounts in 2018 and confirmed that an update would be brought to the next meeting of the Committee.

She further highlighted further key audit risks in the annual accounts as risk of management override, revenue recognition and the risk of fraud in the recognition of expenditure as well as the responses put in place by to each risk.

Within Wider Scope Audits, Ms Jones highlighted financial sustainability as a significant risk. During audit consideration would be given to whether the Board had adequate arrangements in place for managing its financial position and its use of resources including review of financial performance, underlying financial position, financial plans, financial reporting and achievement of savings targets. To ensure a fully rounded assessment, consideration would also be given to forthcoming changes in the leadership team.

Ms Jones confirmed that the audit timetable and fee which would be confirmed at the expected rate.

The independence of Scott-Moncrieff Chartered Accountants as external auditor was noted. Further that the audit would be submitted to Audit Scotland and become a public document.

The Committee noted the fee for the audit work and that the timetable for the 2017–18 had been agreed.

NOTED

15 AUDIT SCOTLAND NATIONAL REPORT

The Committee received a report from the Director of Finance and Performance Management which advised Members of the recommendations made following publication of Audit Scotland National Reports issued since the last meeting of this Committee.

Mr McNaught led Members through the key recommendations, and the Committee was asked to note receipt of three reports which were relevant to TSH.

Firstly, NHS in Scotland – October 2017 which provided an update on the annual performance of the NHS and its future plans. Further, the report on the New Care Model and the report in relation to Workforce Planning were also noted.

NOTED

16 LOSSES AND SPECIAL PAYMENTS POLICY

The Committee received a report from the Director of Finance and Performance Management seeking their review and approval of the Losses and Special Payments Policy, which was due for review every three years.

It was noted that the policy had been reviewed and updated by the Head of Financial Accounts with a minor change made to include volunteers and to remove some duplication of procedures. The monetary limits for reimbursement had not been altered.

If approved the policy would then be circulated for consultation throughout TSH, before being submitted to the Senior Management Team.

The Committee approved the Losses and Special Payments Policy noting that it would be circulated to TSH, with final submission for approval to the Senior Management Team.

DECIDED

Action – Mr McNaught

17 ANY OTHER BUSINESS

On behalf of the Audit Committee, Ms Carmichael expressed thanks to Jean Wade for all her support which had been greatly appreciated, and wished her well for her retirement.

NOTED

18 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 5 April 2018 at 9.45am in the boardroom, The State Hospital, Carstairs.

The meeting ended at 11.55am

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 April 2018
Agenda Reference:	Item No: 20
Sponsoring Director:	Chief Executive
Author(s):	Chief Executive
Title of Report:	Chief Executive's Report
Purpose of Report:	For Information

1 BACKGROUND

The items noted below highlight issues in the Hospital, which do not feature on the Board's formal agenda.

2 GENERAL ISSUES OF NOTE

The Chief Executive will provide the Board with a verbal update on the following issues:

National Boards Delivery Plan
Further progress has been made over March and April on the development of a National Boards Delivery Plan to complement the Regional Plans. Consideration has been given to the areas that National Boards can support the overall National Health and Social Care Delivery Plan and the actions areas of development within the Regional Plans. The draft plan was submitted to Scottish Government on the 3rd of April. This will be considered alongside the Regional plans, including presentation to the Cabinet Secretary and First Minister on 24th April and 2nd May respectively.

The SG Financial Framework is not finalised as yet so we need to link our plan to that once it is available. There is a working assumption of an end of May / start of June publication of the Regional and National Boards Plans. National Boards are sharing the draft plan for feedback and discussion in Board Development Sessions, with formal Board approval taking place once the plans are agreed and published.

The National Boards have met their commitment to reduce costs by £15M in 2017-18. This will be a recurring target for 2018 and beyond.

Financial Recovery Plan
Actions outlined to the Board in February to alleviate year-end financial pressures have been successful thanks to the hard work and flexibility of all of our staff. The Board will achieve a balanced financial outturn for 2017-18. The Director of Nursing and AHP will provide a detailed update in a separate paper.

Support For National Work Streams
The Chief Executive has continued support to national roles and work streams including:

- Chief Executive representative on The National Evaluation Committee
- Chief Executive representative The Scottish Medicines Consortium

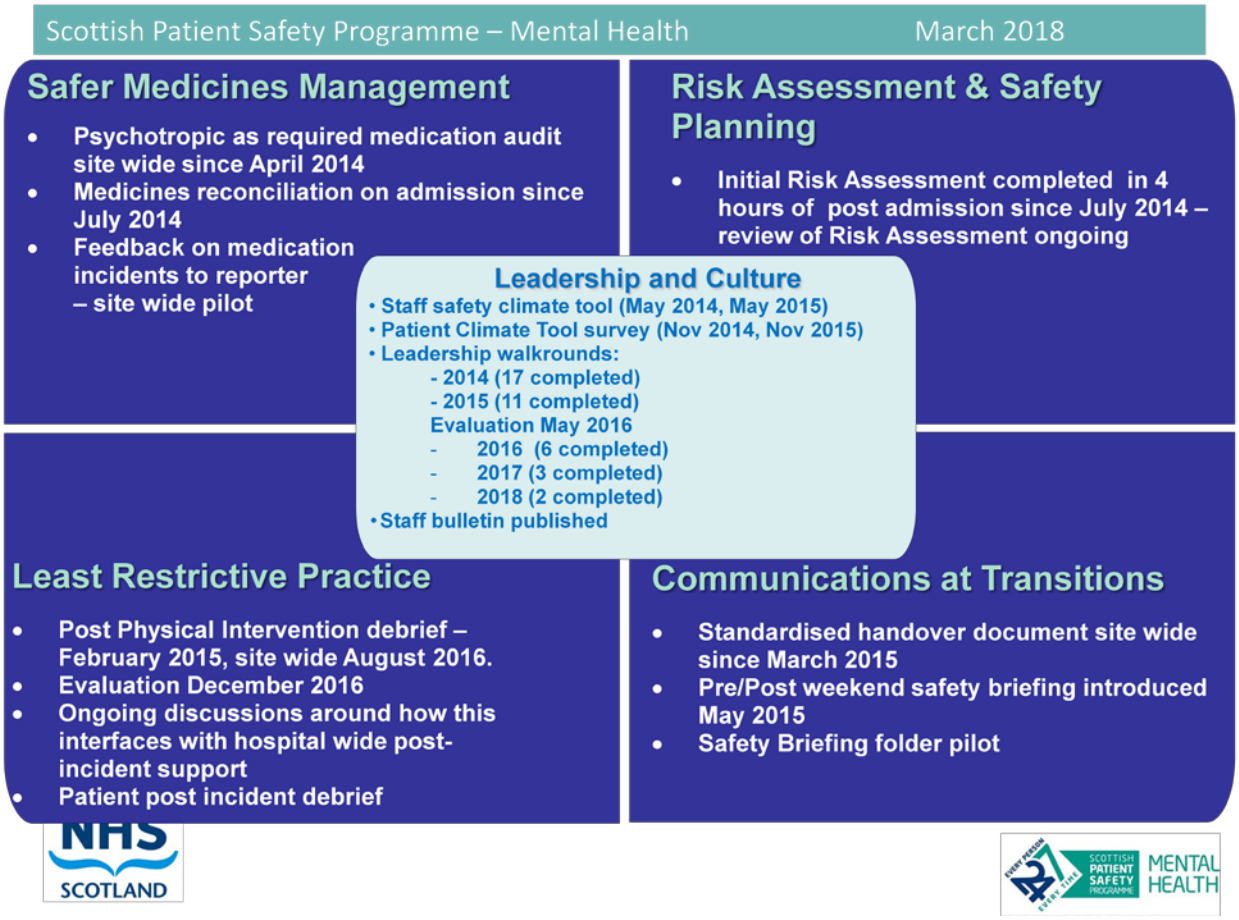
- Chairing The Police Care Network
- Chairing the FCAMHS stakeholder advisory group

3 PATIENT SAFETY UPDATE

A brief summary of SPSP activity across the Hospital in the last two months includes:

Locally, steady progress is being made across all five of the agreed national workstreams.

Work is also ongoing around Improving Observation in Practice.



Work is being co-ordinated via a multi-disciplinary steering group which is meeting regularly. Data suggests that the programme is having a positive impact on practice.

These are evidenced as follows:

- Psychotropic PRN medication documentation ('8 rights') spot check completed in December with median completion of 7.9 against the '8 rights', with one administering less than 10 PRN medications during the week of the spot check

- Initial Risk Assessment completion is less than 4 hours on average. All admissions since January 2017 had all 12 headings completed.

- The SPSP group is also overseeing the roll out of DASA, a structured professional judgment tool which will support decision making regarding how we support our patients on a day to day basis through, for example, enhanced clinical observation. As part of this

work, Essences has been implemented with baseline data now available as a measurement of staff and patient safety and therapeutic milieu.

- Linked to this workstream will be a project on observation practice, which will be a joint improvement project between one of our medical staff who is in the Scottish Improvement Fellowship programme and Nursing. A driver diagram has been started with meetings arranged to agree the supporting measures.

Our programme of leadership walk-rounds recommenced in 2017, with 2 completed since the start of this year. The sharing of information from the walk-rounds has been changed to ensure that the Board are better sighted on the feedback offered during this process. Further walk-rounds have been arranged for 2018 with a different area visited each month.

4 HEALTHCARE ASSOCIATED INFECTION (HAI)

This is a summary of the Infection Control activity from 1st January – 31st March (unless otherwise stated)

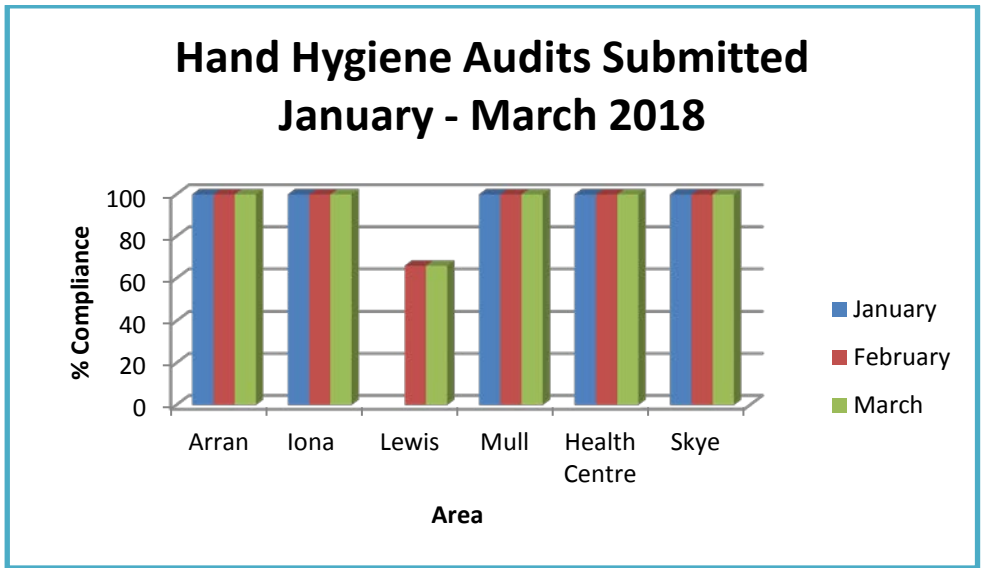
Audit Activity:

Hand Hygiene
During this review period, there was a notable increase in the number of audits submitted towards the latter end of the quarter. Reminders to submit and follow up of non compliance will continue to be carried out by the Senior Nurse for Infection Control.

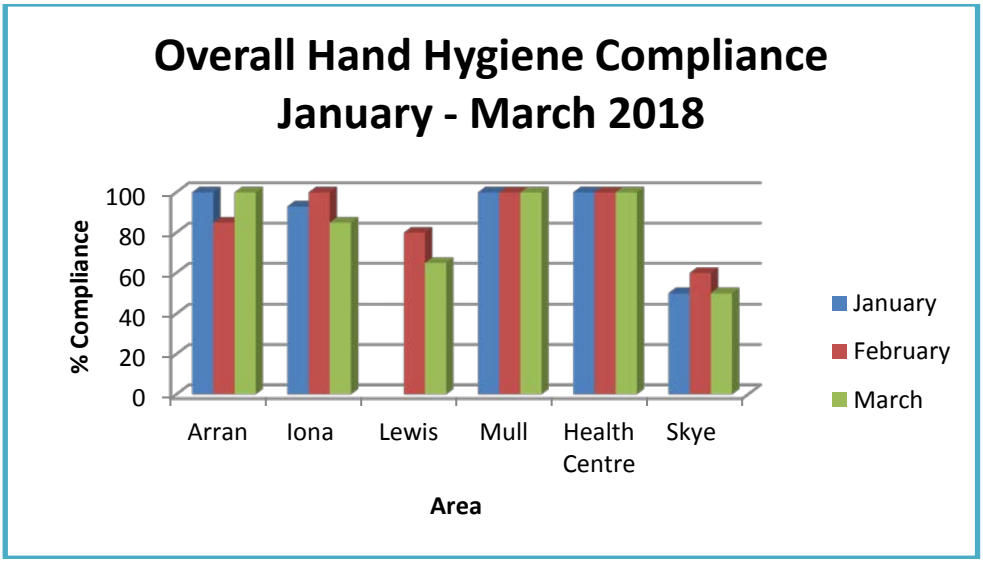
January
19 out of a possible 12 were submitted

February
11 out of a possible 12 were submitted

March
11 out of a possible 12 were submitted



The overall hand hygiene compliance within the hubs varies between 65-100%, Skye Centre 50-60% and health centre consistently attaining 100%.



Following approval by the Senior Management Team both the product and the location of the hand gel within the Skye Centre was changed. This change occurred in September, early indications would show that the positioning and change in product has not made any significant difference. Progress will be monitored by the Infection Control Committee. The existing product remains in situ to provide options for staff.

Healthcare Waste

The data set will is outwith the timeframe for this report.

Workplace Inspections

The data set will is outwith the timeframe for this report.

DATIX INCIDENTS FOR INFECTION CONTROL 1st January – 31st March 2018

Although no data produced for this report all DATIX incidents are reviewed but the SNIC and there were no areas of concern.

Scotland's Infection Prevention and Control Education Pathway (SIPCEP) (previously Cleanliness Champions):

The SIPCEP implantation pathway was approved by the Infection Control Committee in August and by the SMT in September 2017. This has been added to the mandatory modules and will be monitored by the Learning Development. The modules were officially launched in the hospital in November. An update will be provided for the next report. Anecdotal comments would indicate that staff are finding the modules lengthy and require concentration; however it should be noted that completion of the SIPCEP modules is fully supported by the Chief Nursing Officer (June 2017).

Healthcare Environment Inspection (HEI):

The Standards of Dress and Clinical/Non-clinical Uniform Policy has been approved by the Senior Management Team and was launched on Monday 5th February 2018 and audit of same will be undertaken in August 2018.

Hepatitis C Treatment

There have been changes at a national level regarding for the criteria in identifying people who are suitable to receive treatment for Hepatitis C. Previously the eligibility for this depended on the individual's physical condition and progression of disease. In November 2017, the general consensus is that anyone diagnosed with hepatitis C will be eligible for treatment (unless otherwise indicated). Within the State Hospital funding for this treatment is from the patients "home" territorial board. There are currently 4 patients waiting to start treatment.

5 PATIENT ADMISSION / DISCHARGES TO 12 OCTOBER 2017

A detailed report on admissions and discharges is provided to the Clinical Governance Committee on a 6 monthly basis. The following table outlines the high level position from 14 October to 6 December 2017

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds (i.e. those actually available)	108	12	120
Admissions	4	0	4
Discharges / Transfers	6	1	7
Average Bed Occupancy as at 16.04 2018	-	-	108 Patients 90% of available beds 77% of all beds

6 CIR REVIEWS OUTWITH THREE MONTH COMPLETION DATE

There was one Review outwith the three month completion date as follows:

CIR 17/02 Target Date 18 August 2017 Assaults, Lewis – Report is currently in draft format and will be considered at the next Senior Management Team Meeting.

7 NHS 70th ANNIVERSARY CELEBRATIONS

At the February meeting of the Board, it was discussed that we should plan to celebrate the 70th Anniversary of the NHS in Scotland. A number of ideas have been generated, and a small group has now been formed to take these forward.

Proposals are:

- Nationally, there is an exercise to capture and publish 70 stories from Mental Health Nurses. We will be part of this, so can include it as part of our activities.
- Hold a 70th anniversary celebration event with our carers.
- Have a horticulture project where we plant out flowers in a 'NHS 70' in the grounds of the Hospital.
- Focus an art therapy project on the 70th anniversary.
- Have a themed group or discussion through the Patient Learning Centre, looking at what has changed in healthcare delivery over the past 70 years and what might the next 70 years bring.

8 RECOMMENDATION

The Board is invited to note the content of the Chief Executive's report.