THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 25 APRIL 2024
at 9.30am
Hybrid Meeting: in Boardroom and on MS Teams

A G E N D A

9.30am			
1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 22 February 2024	For Approval	TSH(M)24/01
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 24/20
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
7.	**Patient Story:** **"My Sports Journey"** Led by the Director of Nursing and Operations	For Discussion	Presentation
10am	**RISK AND RESILIENCE**		
8.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 24/21
9.	**Finance Report** Report by the Director of Finance & eHealth	For Noting	Paper No. 24/22
10.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 24/23
10.30am	**CLINICAL GOVERNANCE**		
11.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 24/24
10.45am	**BREAK**		

11am	**STAFF GOVERNANCE**		
12.	**Staff Governance Report** Report by the Workforce Directorate	For Noting	Paper No. 24/25
13.	**Implementation of the Health and Care Staffing (Scotland) Act and e-Rostering** Report by the Director of Nursing and Operations	For Noting	Paper No. 24/26
14.	**Whistleblowing:** - **Quarter 4/ Annual Report** Report by the Director of Workforce	For Noting	Paper No. 24/27
11.30am	**CORPORATE GOVERNANCE**		
15.	**Annual Review of Standing Documentation** **(a) Standing Financial Instructions and Scheme of Delegation**	For Decision	Paper No. 24/28
	(b) Standing Orders and Code of Conduct	For Decision	Paper No. 24/29
	Report(s) by the Director of Finance and EHealth Head of Corporate Governance		
16.	**Blueprint for Good Governance – Board Improvement Plan** Report by Head of Corporate Governance	For Decision	Paper No. 24/30
17.	**Annual Delivery Plan 2024/25** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 24/31 **To Follow**
18.	**Communications Update** Report by the Head of Communications	For Noting	Paper No. 24/32
19.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 24/33
20.	**Audit and Risk Committee:** Approved Minutes of meeting held 25 January 2024	For Noting	ARC(M) 23/03
	Report of meeting held 21 March 2024	For Noting	Paper No. 24/34
21.	**Any Other Business**		Verbal
22.	**Date of next meeting:** 12.30pm on 20 June 2024		Verbal
23.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
24.	**Close of Session**		Verbal

Estimated end at 12.10pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 24/01**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 22 February 2024.

This meeting took place in the Boardroom at the State Hospital and also by way of MS Teams, and commenced at 9.30am

Chair:	Brian Moore

Present:

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

In attendance:

Mental Health Manager, Social Work	David Hamilton
Head of Communications	Caroline McCarron
Head of Planning and Performance	Monica Merson
Acting Director of Workforce	Laura Nisbet
Head of Corporate Governance/Board Secretary	Margaret Smith [Minutes]
Director of Security, Resilience and Estates	David Walker
Head of HR, Facilities and Estates, NHSGGC	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone, and noted that there were no apologies for the meeting. He welcomed Mr Wallace to the meeting, noting that he would be commencing in his new role as Director of Workforce on 1 March 2024.

2 CONFLICTS OF INTEREST

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

3 MINUTE OF THE PREVIOUS MEETING

The minute of the previous meeting held on 21 December 2023 was noted to be an accurate record of the meeting subject to minor amendment

The Board:

1. Approved the minute of the meeting held on 21 December 2023.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

There were no matters arising for discussion, from the previous meeting minute. The action list was noted as having no outstanding items.

The Board:

1. Noted the updated action list, with the updates provided.

5 CHAIR'S REPORT

Mr Moore provided an update to the Board in relation to his activities since the date of the last Board meeting. He noted that NHS Chairs had met at the end of January, and that the focus had been on finance and sustainability, and the need for a step change in the ongoing reform programme in order for NHS Boards to achieve balanced budgets. NHS Chairs had noted the approach of the implementation date of 1 April for the Health and Care (Staffing) Scotland Act, as well as the focus on encouraging the uptake of vaccination for seasonal flu and Covid-19 during the winter period. Mr Moore advised that the newly appointed Cabinet Secretary for Health and Social Care, Mr Neil Gray, would meet with NHS Chairs on 6 March 2024.

He also highlighted the publication of the Audit Scotland report, NHS in Scotland 2023, published today and the theme within it relating to the challenging landscape for the delivery of services across NHS Scotland.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

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

He advised that NHS Board Chief Executives meetings had been focused on financial pressures. He noted the expected challenge for the State Hospital (TSH) in terms of achieving a balanced budget in 2024/25 with an expectation of a minimum of 3% in savings across all budgets, and the implementation of the outstanding aspects of the Agenda for Change pay deal agreed for 2023/24. He placed this within the context of the pressures being experienced across NHSScotland, and referenced the Audit Scotland report published today.

Mr Jenkins thanked all staff for their efforts to ensure that excellent progress had been made with respect of the practice of daytime confinement, which had all but been eliminated within TSH. He highlighted the leadership by Ms McCaffrey and Professor Thomson in this regard, and confirmed that they would continue to monitor practice, to embed learning going forward.

He thanked Ms Merson for her contribution in respect of the development of the Annual Delivery Plan which was on track for submission to Scottish Government by the due date of 7 March 2024. This included hosting a planning day for the Executive Team on 15 January followed by provision of an update at the Board Development Session at the beginning of February.

Mr Jenkins advised that an unannounced inspection by the Mental Welfare Commission (MWC) had taken place on 20 February. Ms McCaffrey provided further feedback in this regard, which had been largely positive from the MWC, and had provided good examples of patient activity in Hubs and in the Skye Centre. Staff had supported the visit very well, and patients had had the opportunity to engage directly with the MWC about their care. The inspection included visits to both Arran and Iona Hubs.

There had been two recommendations in respect of administration of legal paperwork, and Ms McCaffrey confirmed that these aspects were capable of rectification and work was in progress to do so. A formal report would be forthcoming from the MWC in due course.

Mr Jenkins also advised that a further update would come to the next Board session in relation to a sustainable financial position which had been reviewed to reflect increased financial pressures, and the mitigations being put in place at TSH to support the achievement of a balanced budget in 2024/25. This would be reviewed by the Corporate Management Team (CMT) and come to the Board for approval at its April meeting.

Mr Currie underlined the particular difficulty in achieving revenue savings in the context of implementation of the Agenda for Change deal for 2023/24 in all its aspects unless these were funded nationally. He also commented that whilst the Audit Scotland report outlined the challenges being faced, these were not unexpected, and it was not clear what reforms could be made that would lead to significant change.

Mr Moore thanked Ms McCaffrey for providing positive feedback arising out of the unannounced visit by the MWC. He noted that the new Cabinet Secretary for Health and Social Care would be meeting NHS Chairs shortly, and would have an opportunity to outline his view on progress of the reform programme and how this would be taken forward.

The Board:

1. Noted the update from the Chief Executive.

7 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 24/02) from the Director of Security, Resilience and Estates, which provided an overview of the Corporate Risk Register including movement on risk gradings

Mr Walker provided assurance that all risks had been reviewed within the prescribed timescale. He noted Risk HRD113 had been added to the register, in relation to the risks associated with governance of the Agenda for Change job evaluation process, with a medium risk grading. He noted the updates made to Risk ND71 - Serious injury or death as a result of violence and aggression, which had been graded as a medium risk which would be monitored regularly. He confirmed that there were two risks graded as being a high risk. The first of these was Risk MD30, Failure to prevent/mitigate obesity and Mr Walker referenced the range of mitigations in place. The second was Risk ND70, Failure to utilise resources to optimise excellent patient care, and mitigations included proactive recruitment and efforts to reduce sickness absence. Mr Walker also advised that work was continuing to further develop the Corporate Risk Register, refreshing the approach to assessment of risk and linking directly to the Corporate Objectives.

Mr Currie noted that it would be helpful to highlight future financial risks to the Corporate Risk Register, revising existing risks to tie these aspects together, as this would help to demonstrate potential impacts and the need for mitigation of these. In response, Mr Jenkins confirmed that a new risk was under development (Risk FD90) relating to financial risk and sustainability; and would be brought to the next Board meeting in April. Mr Walker also commented that as pressures presented, then the individual risks would be reviewed then submitted to each of the related governance committees for their consideration prior to final reporting to the Board.

Ms Radage suggested that in relation to Risk ND70, there should be clarity that the reduction in

sickness absence related to long terms absences, with there having been a slight increase in short term absences over the winter period due to seasonal respiratory disease. It was agreed that the paper would be amended to clarify this.

Action – M Smith

Ms Radage also noted the good progress made in relation to the job evaluation process; but underlined the risk associated to this for TSH in particular as a small Board, and the benefit of further collaboration with other Boards in the future.

Ms Fallon thought that the work conducted to refresh Risk ND71 was helpful, and should be applied across other risks, especially encouraging a "see, think, act" approach. She also asked if managers were provided with training materials for developing job descriptions. Mr Jenkins confirmed that a new approach to assessing risk was under development, and that this would include the points made. Ms Nisbet advised that training materials were made available to managers, based on the national guidance. This was available online for managers so that they would have it to hand, rather than as a one off event.

Mr Moore noted the Board's agreement to the paper being an accurate statement of risk; as well as welcoming the ongoing work to continue to develop it.

The Board:

1. The Board reviewed the current Corporate Risk Register and approved it as an accurate statement of risk.
2. Noted the small amendment to the paper to clarify the position on sickness absence.

8 FINANCE REPORT TO 31 JANUARY 2024

The Board received a paper (Paper No. 24/03) from the Finance and eHealth Director, to provide the detailed financial position as at 31 January 2024.

Mr McNaught summarised the content of the paper, particularly that the Board was on track to achieve a breakeven position at year end, with an underspend position of £0.372m at the end of January. In respect of the capital allocation, he advised that this was being fully utilised in the current year, with a prioritisation of ongoing demands. Mr McNaught also advised that an indicative forecast for the 2024/25 year had been submitted and discussed with Scottish Government.

Mr McNaught also commented on the Audit Scotland report published today, particularly in relation to the position within TSH in terms of recurring to non-recurring savings, compared to NHSScotland overall. The report had outlined the increase in pressure, and the attendant risks for service delivery. He commented on the use of brokerage in NHS Boards and that this was something that TSH had not been required to access. He noted that Directors of Finance were meeting on a weekly basis, with concern in respect of the implementation of the non-pay aspects of the Agenda for Change pay agreement for the current year which would have significant financial impacts.

Mr Currie commended the careful financial management within TSH which meant that the Board was in a strong position for the current financial year. He noted the difficulty in making savings on a recurrent basis going forward, especially as new financial pressures may arise during the course of the coming year. This was of particular concern within a small specialist National Board, whereby it would be problematic to plan any curtailment of services. Mr McNaught agreed with the difficulties posed given the balance between pay and non-pay aspects within the TSH budget; and he gave assurance that should the financial position become more pressured then the consequential risk associated with that would be brought to the Board.

Ms Fallon echoed the remarks made on the strong financial management and leadership for TSH, and asked for clarification as to any increased risk related to Pay As If At Work (PAIAW). Mr McNaught

advised that this had been an unknown variant at the time of reporting; and prudence was used in terms of the value set so that there was no concern to highlight in this respect. Ms Nisbet advised that revised information had been received within the last 24 hours allowing further financial analysis. Mr McNaught confirmed that this would be updated accordingly in future reporting.

Mr McConnell noted the ambivalence between recurring and non –recurring savings and how this was reported across NHSScotland. He asked about the costs related to ward nursing, and the level of confidence as to whether there was a risk to the breakeven position for year-end. Mr McNaught confirmed that the financial risks related to the resourcing required for increased clinical activity were included in projections, including patients requiring to be boarded out to general hospital settings for care. Mr Jenkins added that Ms McCaffrey was developing a position paper on nursing resourcing costs, which would include the basis for planned, recurring costs as well as those related to clinical pressures and the impacts caused. The intention was to demonstrate the way forward to manage the peaks and troughs, and exercise control over the budget.

Mr Moore summarised for the Board, noting good financial management and the expectation of a breakeven for yearend. Further reporting would include the points discussed including further narrative on recurring to non-recurring savings position, and management of nurse resourcing.

The Board:

1. Noted the content of the report.
2. Noted future reporting in respect of outlining fuller background to savings, and nurse resourcing.

9 INFECTION PREVENTION AND CONTROL REPORT

The Board received a paper (Paper No. 24/04) from the Director of Nursing and Operations, which provided an overview of activity in infection prevention and control across the hospital in the period since the last Board meeting. Ms McCaffrey summarised the report, which demonstrated continued robust governance in relation to Healthcare Improvement Scotland (HIS) Standards 2022. She also noted the proactive way in which any minor issues arising were picked up on and actioned by the Infection Prevention and Control Group.

Mr Moore noted that this report had come directly to the Board as part of its consideration of risk and resilience in the period following recovery from the Covid-19 pandemic. There were no continuing concerns, and detailed oversight was taken by the Clinical Governance Committee at its quarterly meetings. For this reason, it may not be necessary for this report to continue to be presented as a standing item for each Board meeting, although annual reporting could continue. Ms Fallon agreed with this point, in her remit as Chair of the Clinical Governance Committee. She also asked if more background could be provided in relation to the “Five Key Moments” promotion of hand hygiene standards. This was provided electronically to the Board during the meeting, with an assurance that posters were positioned throughout the hospital.

Mr Moore noted agreement that reporting could be routed through the Clinical Governance Committee As a standing item, with consideration as to the Board receiving annual reporting directly.

Action – Ms Smith

The Board:

1. Noted the content of report.
2. Refresh Board Workplan in terms of reporting of this item

10 BED CAPACITY REPORT

The Board received a paper (Paper No. 24/05) from the Medical Director, which detailed the position for

bed capacity within TSH in the context of the wider Forensic Network. The paper confirmed patient numbers as at the end of January, and the numbers of admissions and transfers throughout December and January.

Professor Thomson presented the key highlights of the report noting that it also demonstrated internal patient move across services within TSH, which was encouraging in terms of patient progression. The ID service remained three over its allocation of 12 patients but this was managed through two wards as a supportive environment. There continued to be natural variation in overall numbers with 95 patients within the hospital as of today's date but eight referrals had been received in the past two weeks. There were no patients within TSH under the exceptional circumstances clause at the present time. She also noted the capacity reporting prepared by the Forensic Network, and that these were being revised

Ms Fallon asked if there was any update on bed capacity within the Orchard Clinic, medium secure within NHS Lothian, and Professor Thomson confirmed that the repair programme was continuing with a completion date not yet confirmed. However, most pressures were being experienced in the west of the country.

Mr McConnell asked about capacity within the ID service, and whether there were any challenges for service delivery Professor Thomson advised that there were two wards and no issue on capacity within Iona Hub. This enabled a quieter environment for this patient cohort and meant that patients were placed within the correct service. Mr McConnell also asked about the numbers of patients awaiting transfer to lesser security, and Professor Thomson advised that these figures were at typical levels presently, with the majority of patients who had been fully accepted for transfer able to move on. The position was improving, with the numbers of appeals against excessive security reducing.

Mr Moore asked about reporting of occupancy rates within services within TSH, and if this could be shown longitudinally over a longer period to give a wider picture of the how the revised clinical model was impacting in terms of patient flow. Professor Thomson advised that this could be provided, and was already included in reporting at committee level, emphasising that a progressive model of care for patients was at the heart of the clinical model, whenever this was clinically appropriate.

Action – Professor Thomson

The Board:

1. Noted the content of report.
2. Requested further longitudinal reporting as part of this report for the Board.

11 SUPPORTING HEALTHY CHOICES

The Board received a paper (Paper No. 24/06) from the Medical Director to provide an update on the Supporting Healthy Choices workstream Improvement Programme.

Professor Thomson advices that a best practice guidance had been developed within TSH: Moving Towards a Healthier State Hospital, and this had been sent to Public Health Scotland for review. This linked directly to the driver diagram previously developed, and the overall aims of the programme. An action plan was needed to lead on from this, including measurement of outcomes based on Key Performance Indicators including BMI and patient activity levels. The focus would be on new admissions in particular to take preventative action on weight gain during patients initial months within TSH.

Mr Jenkins added that the external review form Public Health Scotland was welcome. It may provide further opportunity for support and guidance from them to help TSH in tackling this complex and problematic issue.

Mr Moore summed up for the Board, welcome the active approach taken and the approach made to Public Health Scotland.

The Board:

1. Noted the content of this update.

12 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 24/07) which provided update reporting on quality assurance and improvement activities since the date of the last Board meeting.

Ms Merson summarised the key aspects of reporting and noted that two clinical audits had been completed and actioned, each relating to different aspects of record keeping, which had shown excellent levels of compliance. The hospital wide variance analysis demonstrated very high levels of completion. Some key points were the increase in carer attendance over the quarter; whilst there had been a decrease in Positive and Negative Syndrome Scale (PANSS) completion. Ms Merson also noted the pilot being taken forward to test the transfer of VAT data to the RiO system.

She also highlighted recent activity through the Quality Forum, and that details of a case study in respect of reflective practice was included in reporting. She confirmed that a Project Manager commenced in their role on 19 February, and this would help to further support Realistic Medicine activities, with the updated action plan due to be submitted to Scottish Government by 15 March. Finally, she acknowledged that four evaluation matrices still awaited review and had been outstanding for some time.

Mr McConnell asked about the significance of the decrease in the PANSS completion rate, specifically as to what a reasonable target should be for this. Professor Thomson advised that this was a mechanism used for major mental illness patients only, mainly in relation to schizophrenia. Further, that PANNS would not necessarily be appropriate but that rates of 60- 70% completion should be expected. It was the gold standard for measuring improvement in psychotic illness. She provided further background to this, in that there were two parts with one completed by medics, and the second by the key worker (or someone who knew the patient well). Both aspects were being reviewed in terms of awareness and educational support aiming to improve completion rates.

Ms Fallon thanked Ms Merson for comprehensive reporting, and was pleased to see the results of the clinical audits relating to record keeping. She asked for further background about the case study included in the report. Ms Merson explained that this related to providing support to help embed reflective practice. Staff within Lewis 2 took part and used the Wellbeing Centre to support staff further and try to strengthen team cohesion and morale. Ms Fallon also asked about the Quality Strategy, and how this would be developed and reported; and Ms Smith advised that this had been under discussion with the Head of Clinical Quality with a suggestion that it would be helpful to bring an update to the Board Development Session scheduled for 2 May. There was agreement around the table to this proposal.

Action – Ms Smith/Ms Merson

Mr Moore noted the evaluation reports which had been outstanding for some time, and it was agreed that there should be a focus on completion as a priority, and an update in the next report.

Action – Ms Merson

Mr Moore noted the excellent level of assurance that the report provided, and noted thanks on behalf of the Board to the Quality Forum for the considerable range of work progressed.

The Board:

1. Noted the content the report and updates contained therein.
2. Agreed that the Quality Strategy would be part of the agenda at the Board Development Session on 2 May.

3. Requested further focus on closing outstanding actions as reported in the evaluation matrix.

13 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 9 November 2023; as well as a summary report (Paper No 24/08) of the key areas of reporting and discussion at the meeting which had taken place on 8 February 2023.

As Chair of the Committee, Ms Fallon highlighted that further reporting would be brought back to the Committee on the Significant Adverse Event Review in relation to the administration of medication.

The Board:

1. Noted the content of the approved minutes CGC(M) 23/04.
2. Noted the update in relation to the meeting held on 8 February 2024.

14 STAFF GOVERNANCE REPORT

The Board received and noted a report from the Acting Director of Workforce (Paper No. 24/09) which summarised the key aspects of workforce performance across a range of metrics. It was acknowledged that this report had been submitted in full to the Staff Governance Committee during the previous week, and had been reviewed and discussed in detail.

Ms Radage, as Chair of the Committee, added her agreement to this, noting the range of reporting and also the way in which each thread of governance relating to workforce matters linked together cohesively.

Mr Jenkin asked the Board to note that although there had been an increase in sickness absence during December and January, this was related to short term absences with the main reason for absence related to winter viruses correlating to the position across population as a whole.

Mr Moore also noted the helpful discussion during the Committee in respect of gender balance in the workforce, and that this would be an area for future review.

The Board:

1. Noted the content of the report

15 IMPLEMENTATION PLANNING – HEALTH AND CARE STAFFING (SCOTLAND) ACT/ E-ROSTERING

The Board received a report from the Director of Nursing and Operations (Paper No. 24/10) which summarised the position on the implementation of the Health and Care Staffing (Scotland) Act 2019 (HCSA) and the adoption of e-rostering within TSH. It was noted that this report had been submitted to the Staff Governance Committee in the previous week, with detailed oversight taken. Ms McCaffrey confirmed that there were no further updates to this position.

Mr Moore commented that the Board had previously asked for this to be a standing item until the date of implementation, this being 1 April 2024. Therefore, at the next Board meeting in April consideration could be taken as to whether detailed reporting was required at each Board meeting, whilst noting the need for an annual report. He noted the assurance taken at the standing committees of the Board across a range of metrics more generally, which would allow the Board to refresh its workplan, in terms of whether direct oversight was required.

The Board:

1. Noted the content of this update.

16 WHISTLEBLOWING QUARTER 3 REPORT

The Board received a paper to report any developments during Quarter 3 (Paper No. 24/11).

Ms Nisbet advised that that no new cases had been received during this period, and that therefore there were no cases under review or outstanding.

Mr Moore highlighted the helpfulness of the regular bulletin published by the office of the Independent National Whistleblowing Officer (INWO) and a link was provided to the Board.

The Board:

1. Noted the content of the report.

17 STAFF GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 16 November 2023; as well as a summary report (Paper No 24/12) of the key areas of reporting and discussion at the meeting which had taken place on 15 February 2024.

As Chair of the Committee, Ms Radage asked the Board to note in particular the update received in respect of the Occupational Health Service, and also that the Organisational Development Strategy was being progressed.

Mr Moore confirmed that the Board had taken note of this position.

The Board:

1. Noted the content of the approved minutes SGC(M) 23/04.
2. Noted the update from the meeting held on 15 February 2024.

18 CORPORATE OBJECTIVES 2024/25

The Board received a paper (Paper No. 24/13) from the Head of Corporate Governance, Mr Moore introduced this by saying that the objectives set out strategic priorities for the coming year although this may be impacted by financial pressures.

Ms Smith provided a summary of the key revisions made, noting that the Board undertakes this review annually to set out key strategy and align this to the ADP as well as financial and workforce planning. The objectives were set out under the four pillars of Better Care, Better Health, Best Value and Better Workplace, and had been discussed and agreed firstly through the CMT. Ms Smith asked the Board to note that there continued to be close liaison with the Mental Health Directorate, in terms of performance and delivery with the next formal quarterly sponsor meeting arranged for 23 April 2024. It was expected that the Annual Review would be arranged to take place in autumn 2024, to review performance during 2023/24. She noted that the Board would be meeting on 7 March to follow up on the recent self-assessment exercise and to take forward the associated improvement plan. Finally, she noted that at the time of reporting, national guidance was awaited in terms of the review of the national framework for the delivery of forensic mental health services led by Scottish Ministers.

Ms Smith highlighted the key changes made including tailoring the clinical model to reflect the graduated clinical and security steps for patient progression, as well as eliminating use of daytime confinement. There as a commitment to accessibility for patients, families and carers, as well as

national collaboration with the Healthcare in Custody Network. The commitment to a sustainable finance model was a key objective and this was framed within the national context. Further priorities included implementation on health and care staffing legislation, agree a new strategy for organisational development, and a continued focus on recruitment and retention of staff within a staff wellbeing offer.

Ms Fallon welcomed the report as a helpful way to summarise priorities, and also as part of her role as Chair of the Clinical Governance Committee; the objectives could be mapped across to the workplan. She asked for additional clarity on point six under Better Health, relating to the wider forensic estate, and Mr Jenkins advised that the intention was to ensure a seamless transition of patents from TSH when clinically appropriate. It was agreed that this wording should be amended to reflect this.

David McConnell commented that the objectives were a helpful presentation of the Board's aims for the coming year, and asked if it would be possible to provide a version of the document to show the changes made. Brian Moore agreed that this would be useful and would be provided going forward. He summed up and noted the Board's approval of the Corporate Objectives for 2024/25.

Action(s): Margaret Smith

The Board:

1. Approved the Corporate Objectives 2024/25 subject to the amendment to wording as discussed.
2. Requested a version to be circulated tracking the changes made.

19 PERFORMANCE REPORT QUARTER 3

The Board received a paper (Paper No. 24/14) from the Head of Planning and Performance to provide a high-level summary of organisational performance for Quarter 3. Ms Merson provided a summary of the key aspects of reporting, focused on the areas which were below their target level.

This included six monthly reviews of care and treatment plans, which had moved into the red zone, with a falling performance. Ms Merson advised that there was a difficulty in the administration of the documentation relating to reviews, and that this had been picked up by the Organisational Management Team leads, with actions put in place for improvement. There had been a drop in the numbers of patients recorded as being involved in psychological therapies, placing performance in the red zone for this quester. Ms Merson outlined the factor contributing to this, including capacity within the Psychological Therapies Service, as well as the pressures experienced in ensuring risk assessment work was prioritised to support patient moves. Resourcing within the department had improved through recent recruitment, and the timing of trainee positions within the team would be staggered to achieve a more stable position going forward.

Ms Merson also advised that the level of patients achieving 150 minutes of exercise weekly had fallen to 58% meaning that this target was in the red zone, and that seasonal factors had an impact at this time of the year. The Activity Oversight Group were exploring ways to mitigate this and how to vary the offer to patients for activities. The indicator for patient BMI remained below target for this quarter.

Finally, Ms Merson highlighted the rate of sickness absence, which remained in the red zone, and that the factors impacting this having already been noted during the meeting.

Mr Moore welcomed the high level reporting, with detailed oversight being taken at committee level. Mr Currie agreed that it was helpful to see the trend reporting, which would enabled close scrutiny of performance and would help to inform the Board's response. He noted that this would be particularly helpful in terms of focusing investment of resources and effective decision-making. There was agreement around the table on the benefit of longitudinal data and analysis.

In respect of patient activity, Ms Radage asked whether it would be possible to expand the data reporting to the full year, and Ms Merson noted that at present reporting reflected the performance since the change was made in the target itself. She agreed to revise reporting to reflect a longer period.

Action – Ms Merson

Mr Jenkins added that this target reflected local ambition in terms of patient activity, and it may be helpful to think about it in terms of the total levels of activity and how this was measured. The work take forward by Supporting Healthy Choices and link in to Public Health Scotland for their input would also add to the overall approach, and the context within which this target was set. Mr Moore commented on the balance between setting a quantitative target for exercise; and consideration of the more qualitative aspects in terms of what would be most impactful.

Professor Thomson advised that the suggestion for target change had been based on the recommendation of the Physical Health Steering Group, and that it was not just aspirational but reflected what was through tot be realistic and capable of achieving. It also correlated to the target set for the general population by Scottish Government, and that it was incumbent on TSH to give patients the opportunity for activity as well as the same core public health messaging as wider society.

Mr Currie added that additional context would help to focus on what was actually working in terms of patient physical health, and that this may mean that the TSH patient population did reflect the general position in society.

The Board was content to note this detailed update and the information provided as part of reporting.

The Board:

1. Noted the content of the report.
2. Requested further data over 12 month period in respect of patient activity

20 NETWORK AND INFORMATION SYTEMS (NIS) REPORT

The Board received a paper (Paper No. 24/15) from the Finance and eHealth Director, to confirm the outcome of the review conducted by the Cyber Security Scotland during October 2023. Mr McNaught confirmed that this had now been finalised resulting in a compliance rating of 76%, which represented considerable improvement on the rating for 2022. He also outlined the next stages, which included an improvement plan for further progress during 2024.

The Board thanked Mr McNaught and his team for the progress made, and noted the improved position.

The Board:

1. Noted the content of the report.

21 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 24/16) to summarise the present position on the Perimeter Security and Enhanced Internal Security Systems re-fresh project. Mr Walker summarised the main points, including that the timeline for completion was now expected to be July 2024. He emphasised that regular strategic meetings continued to take place with Securitas, with their UK General Manager taking leadership of completion of this project.

He confirmed progress in relation to the new Personal Attack Alarms system which was due to go live in the first week of March; as well as ward CCTV which was due to go live during March. He advised that Scottish Government were being kept informed of progress and any financial implications. Mr McNaught added that this had been noted at the meeting earlier this week with Scottish Government in relation to the financial position overall, with confirmation this this would be reported to the Capital Investment Group for continuing awareness.

The Board noted that a further update would be presented in a private session of the Board, given the

security and commercial sensitivities of reporting.

The Board:

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

22 AUDIT AND RISK COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 28 September 2023; as well as a summary report (Paper No 24/17) of the key areas of reporting and discussion at the meeting which had taken place on 25 January 2024.

As Chair of the Committee, Mr McConnell highlighted the indicative plan submitted by external auditors, dedicated reporting on financial risk and consideration of how that would be presented as well as a range of annual reporting.

The Board:

1. Noted the content of the approved minutes ARC(M) 23/04.
2. Noted the update from the meeting held on 25 January 2024.

23 ANY OTHER BUSINESS

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

24 DATE AND TIME OF NEXT MEETING

The next public meeting would take place at 9.30am on Thursday 25 April 2024.

25 PROPOSAL TO MOVE TO PRIVATE SESSION

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

26 CLOSE OF MEETING

The meeting ended at 11.45am

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 24	Corporate Risk Register	Amend paper 24/02 to clarify position on sickness absence	M Smith	Immediate	Paper amended prior to publishing. **CLOSED**
2	February 24	Infection Prevention and Control Report	Refresh Board Workplan in terms of reporting of this item	M Smith	Immediate	Board Workplan amended, and quarterly reporting added to Clinical Governance Committee**.** **CLOSED**
3	February 24	Bed Capacity Report	Include longitudinal reporting of this to the Board	L Thomson	April 2024	**April 2024:** Longitudinal data added to report – on today's agenda
4	February 24	Quality assurance and quality improvement	Provide update regarding the Quality Strategy and reporting at the next Board Development Session scheduled for 2 May	M Smith / M Merson	May 2024	**April 2024:** Quality Strategy being progressed. Will be discussed at Board development session on 2 May 2024. **CLOSED**

5	February 24	Quality assurance and quality improvement	Further focus on closing outstanding actions as reported in the evaluation matrix and provide update at next Board meeting	M Merson	April 2024	**April 2024:** Update in report on today'agenda There has been some progress with closing some of the outstanding actions within the evaluation matrix GAP analysis meeting is being arranged for mid May to discuss the SIGN Stroke guideline with a view to submitting to the Physical Health Steering Group in July/August 2024.
6	February 24	Corporate Objectives 2024/25	Amend corporate objectives providing clarity on transfer of patients to medium secure. Circulate version to Board to highlight changes made throughout.	M Smith	Immediate	**Corporate Objectives amended and published. Version circulated to highlight changes made. CLOSED**
7	February 24	Performance Report Quarter 3	Revise reporting to reflect a longer period	M Merson	June 2024	**April 2024:** Data within this report is being redesigned and wherever possible trend analysis will be incorporated in next report.

Last updated – 09.04.24 L. Kirk

Paper No: 24/21

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 08
Sponsoring Director:	Director of Security, Estates and Resilience
Author(s):	Risk Manager
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

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

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix 1.

3.2 Out of Date Risks

All risks are in date.

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

N/A

3.4 Corporate Risk Register Updates

FD90: Failure to implement a sustainable long term model has increased from Medium to High. Full risk assessment is available in Appendix 2.

CE11 – Risk of Patient Injury – Risk changed from Extreme x Rare to Moderate x Unlikely. Last years data has been reviewed and minimal incidents have been recorded. Recent patient injury reportable to HSE has increased likelihood from Rare to Unlikely. Impact reduced from Extreme to Moderate which meets the impact level of latest incident.

CE14 – Covid 19 – Risk reduced to Minor x Rare giving a low grading and meeting target level. The risk focusses on the possibility that Covid-19 could negatively affect the hospitals delivery of services. While cases are still being recorded, the effects on services in TSH over the last 6 months have been negligible. Controls measures in place in TSH can adequately mitigate risk and lack of disruption to services provide assurance.

ND73 – Lack of SRK Trained Staff – No incidents recorded in the last years that specify this risk which now meets the criteria for 'Rare' and giving an overall Low grading.

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has **3** 'High' graded risks:

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

Monthly Update:
Overweight and obesity in February was 83.7% (with 7.1% data missing – increased from 2.9% in Dec)

- The Healthy Living Group is anticipated to be delivered early summer, the program is under review to update and agree a more sustainable format. Cooking sessions will not form part of the next group but may be facilitated by the Occupational Therapist. An informal weekly weight management group is hoping to be delivered by the multi-disciplinary team with weekly anthropometric data obtained for evaluation. This group will form part of the peer support and maintenance support groups for weight management in the hospital.
- Some GLP-1 agonists are available for use in weight management and this has commenced within the hospital on a named patient basis.
- From a physical activity perspective, quicker routes to sports and Skye Centre assessment with minimum 2 sports placements for new admissions.
- Skye Centre Activity staff provide beneficial support as part of their remit, to support patient's activities and walks.
- Hub areas open now offering more activity to patients off ward, support from Occupational Therapists and clinical staff allow this to take place when staffing resource permits.
- The Health psychologist is supporting a key role in the developments of the SHC remit, with current regard to the guidance document and action plan being jointly developed. Supporting group and Individuals who are hard to reach and with complex physical health needs

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

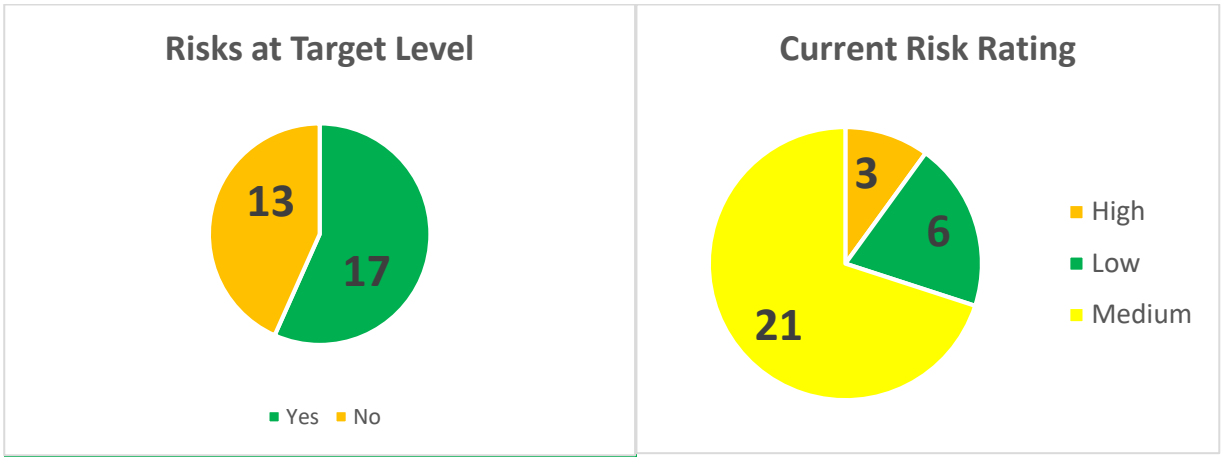
Monthly Update:

- E-Rostering continues to be implemented across hospital, Project Manager has been appointed to bring project to close.
- A proactive recruitment plan is in place to ensure posts are filled in a timely manner
- Proactive work on the organisations absence management approach
- Risk register and risk assessment also completed. Numbers of incidents are reducing overall after a small spike over the festive period, full closure incidents have decreased significantly.
- The risk will be fully refreshed taking into account new data sources including activity levels and RAG Status to ensure an accurate picture of the hospitals situation is available at each review.

Finance Director: FD90: Failure to implement a sustainable long term model

Risk FD90 was revised to reflect the national financial pressures as highlighted by SG communications in January and February 2024 – as issued to Chairs, Chief Executives and Directors of Finance – specifically focussing on expected funding shortfalls and significant budget restrictions for 2024/2025

3.6 Risk Distribution



Currently 17 Corporate Risks have achieved their target grading, with 13 currently not at target level. 2 risks have reduced to low giving us an at target majority for the first time in last few years.

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

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely			ND70	MD30	

Possible			CE12, SD57, FD91, FD99. HRD113, ND71	FD90	
Unlikely			MD33, HRD110, FD96, FD98, CE11	MD34, SD51, SD50, SD54, HRD111	
Rare		CE14	FD97, CE13, ND73 SD52, HRD112	MD32, SD56,	CE10, SD53, CE15

Review Periods:

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

3.7 CRR Development

The Risk management team are continuing to review and refresh the risk management process and a proposal on a new approach was presented and discussed with the Board Members at the Board Development session on 7 November. Board Members were content with the approach being taken and Risk Management will now make a formal approach to CMT and the Board to ratify the way forward. This was presented to CMT in early January paving the way for a review to take place of the current Corporate Risk Register and ensure the risks are aligned to the Strategic Objectives. Work is ongoing within the Risk and Resilience Team to identify the first areas to be reviewed.

Current Progress:

- Nursing Directorate review is 66% complete with ND71 and ND73 having been fully reviewed and positive feedback received about new format. N70D currently being reviewed and will be shared with relevant groups when complete. The risk will be fully refreshed taking into account new data sources including activity levels and RAG Status to ensure an accurate picture of the hospitals situation is available at each review.
- Exploration of Datix Incident Management System underway in preparation for transfer of Corporate Risk Records. The Risk Manager has made the required changes to the system and a small set of risks have been uploaded to the system for testing.
- The appointment of the Risk and Resilience Support Officer has allowed the team to focus on the Local Risk Register. Work is currently underway to update all records, schedule in reviews and look to begin preparation required to move Local Risk Assessments to the Datix System.
- Security Directorate CRR review has started and meeting will be arranged with Director to approve and finalise any suggested changes.

4 RECOMMENDATION

The Board are asked to endorse the current Corporate Risk Register as an accurate statement of risk.

Paper No: 24/21
MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The report provides an update of the Corporate Risk Register.
Workforce Implications	There are no workforce implications related to the publication of this report.
Financial Implications	There are no financial implications related to the publication of this report.
Route To Board Which groups were involved in contributing to the paper and recommendations	CMT and Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks related to the publication of the report.
Assessment of Impact on Stakeholder Experience	There is no impact on stakeholder experience with the publication of this report.
Equality Impact Assessment	The EQIA is not applicable to the publication of this report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	The Fair Scotland Duty is not applicable to the publication of this report.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Paper No: 24/21

High Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	08/05/24	Clinical Governance Committee	Monthly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	08/05/24	Clinical Governance Committee	Monthly	-
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Major x Almost Certain	Major x Possible	Moderate x Rare	Finance & Performance Director	Finance & Performan ce Director	14/05/24	Finance and Performance Group	Monthly	↑

Medium Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	08/06/24	Corporate Governance Group	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Moderate x Unlikely	Moderate x Rare	Chief Executive	Head of Risk and Resilience	07/06/24	Clinical Governance Committee	Quarterly	↑↓
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Head of Risk and Resilience	07/06/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	08/06/24	Covid Inquiry SLWG	Quarterly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	15/07/24	Clinical Governance Committee	Quarterly	-

Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	15/07/24	Clinical Governance Committee	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	15/07/24	Clinical Governance Committee	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	08/05/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	08/05/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	08/05/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	08/05/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Unlikely	Moderate x Rare	Security Director	Head of Estates and Facilities	08/05/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	08/05/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate ND 71	Health & Safety	Serious Injury or Death as a Result of Violence and Aggression	Extreme x Almost Certain	Moderate x Possible	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	15/07/24	Clinical Governance Committee	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Likely	Moderate x Possible	Moderate x Possible	Finance & Performance Director	Head of eHealth	08/06/24	Finance and Performance Group	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	08/06/24	Information Governance Committee	Quarterly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Likely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth/ Info Gov Officer	08/06/24	Information Governance Committee	Quarterly	-

Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Possible	Moderate x Rare	Finance and Performance Director	Head of eHealth	08/06/24	Information Governance Committee	Quarterly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	HR Director	HR Director	16/07/24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Moderate x Possible	Moderate x Unlikely	HR Director	HR Director	16/07/24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 113	Service/Business Interruption	Job Evaluation and impact on services in TSH	Major x Possible	Moderate x Possible	Negligible x Unlikely	HR Director	HR Director	16/07/24	HR and Wellbeing Group	Quarterly	-

Low Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	12/08/24	Corporate Governance Group	6 monthly	-
Corporate CE 14	ALL	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Minor x Rare	Minor x Rare	Chief Executive	Senior Nurse for Infection Control/ Risk Manager	07/06/24	Corporate Governance Group	6 Monthly	↓
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Rare	Moderate x Rare	Director of Nursing & AHP	Director of Nursing & AHP	15/07/24	Clinical Governance Committee	Quarterly	↓
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	27/07/24	Security, Risk and Resilience Oversight Group	6 monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	06/09/24	Information Governance Committee	6 Monthly	-

Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Rare	Moderate x Rare	HR Director	Training & Professional Development Manager	16/07/24	Clinical Governance Group	6 Monthly	-

Appendix 2

Failure to implement a sustainable financial model

Corporate FD 90

Category	Financial	Risk Owner	R. McNaught	Action Officer	R. McNaught

Risk	
There are risk elements to the financial integrity of the organisation at this point in the year: ▪ Capital Funds – There is insufficient funding available to support a planned and preventative maintenance programme. ▪ Revenue Funds – There is insufficient funds to meet the Boards activity to achieve savings and break even. ▪ Risk of failure to have the long-term financial forecast approved by SGHD.	Complete the relevant details of the operation/ activity giving risk to the risk

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

Hazards		
▪ Levels of unidentified / non-recurring savings ▪ Pressure of national boards' collaborative savings demands ▪ Failure to manage existing known pressures and funded commitments ▪ Failure to plan for future known and unforeseen pressures.		Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
Individuals or groups exposed	The whole organisation	Highlight those who would be affected by risk

Benefits	
▪ Focused revised budget setting process and increased financial oversight, awareness and engagement. ▪ Increased awareness across management team of budgetary position and pressures – enabling realistic identification of savings. ▪ Enhanced governance arrangements across the Board and Standing Committee, and to operational level with local teams.	Detail any benefits associated with this risk being realised. (e.g. cost savings)

Existing Control Measures	List any existing measures in place to mitigate this risk.
▪ Budget reviews will take place formally on a monthly basis with each Directorate area. ▪ Sickness monitoring by Chief Executive and HR. ▪ Invest to save to minimise overtime usage across all areas ▪ The introduction of a vacancy management review process at executive level. This will include a risk assessment process associated with the decision to fill or not fill a post. ▪ Director level approval for authorisation levels. ▪ Review of the presentation of monthly finance data at individual Directorate level. ▪ Monthly submission and review of finance return are likely to continue, frequency to be determined. ▪ Consideration given to contingent funding.	

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

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the risk occurring and the impact it would have and determine the overall level of the risk.	Impact/Consequence (use descriptor relevant to proposal and select level of impact)	Likelihood	Rating R= I/C x L
Initial Risk Rating	*Moderate(3)*	*Unlikely (2)*	*Medium (6)*
Target Movement	↔	↓	↓
Target Risk Rating	*Moderate(3)*	*Rare (1)*	*Low (3)*
Current Risk Rating	Major (4)	Possible (3)	High (12)

Further control measures required	

▪ Review of every budget establishment – process underway ▪ Prioritisation of plans which do not involve funding (or further funding) ▪ Review of SLAs (ongoing) ▪ Reviewed supply cost and overspend lines for potential reductions. ▪ Review longer-term projections for sensitivities and potential budgetary pressures. ▪ More in-depth analysis of opportunities from Anchors approach. ▪ Review of the benefits brought by digital technology. ▪ Reduce dependency on non-recurring savings. ▪ Review of all travel and training costs. ▪ Staff suggestions scheme on financial efficiency opportunity. ▪ Consider what materials are printed ▪ Benefits analysis of current service provision to ensure best value for money is delivered ▪ Keep national collaboration opportunities under review	Include any additional controls identified to eliminate or reduce the risk further.

Assurances	What assurances are there that current controls are effective? (Internal and external)
▪ Executive level grip of the challenge ▪ Enhanced monthly scrutiny and reporting process ▪ Quarterly finance statement to each governance committee ▪ Internal Audit and External Audit assurances. ▪ Notification to Audit & Risk Committee for monitoring and TSH Board for approvals. ▪ Scottish Government Quarterly Review Process	

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

Date Risk Implemented	July 2018
Date Last Review Completed	13 February 2024
Completed by	Robin McNaught, Finance and eHealth Director
Review Date	15 May 2024
Reviewed by	Robin McNaught, Finance and eHealth Director

Complete this section if risk is being escalated to risk register then refer to risk register guidance for next steps

Group monitoring risk	CMT and TSH Board

Key Performance Indicators	Detail any existing KPIs that would link to risk, and show

	performance against risk

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 09
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 March 2024
Purpose of Report:	To note update on current financial position

1 SITUATION

This report provides information on the financial performance, which is also issued monthly to Scottish Government (SG) along with the statutory financial reporting template.

The Board is asked to note the Revenue and Capital Resource outturn and spending plans.

2 BACKGROUND

The approved annual operating plan for 2023/24 has been submitted to SG and signed off, with regular meetings between TSH and SG to monitor progress against targets.

Any remaining residual Covid-related costs are now recognised through specific directorates under "business as usual" and continue in this manner with due recognition of the resultant pressures from any additional posts therefrom.

Any delay costs from the Perimeter Project, which are being monitored by the Project Board and are reported directly to the Board, are reviewed, quantified for consideration, and reported appropriately.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £45.446m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and additional allocations as anticipated: AME Provisions RRL, AME Impairment RRL, PPE RRL.

The March accounts show an underspend to date of £0.015m, including an unscheduled adjustment required for year-end provisions with regard to NSS recharges, which remains under review.

Budgets were revised for Ward Nursing to mainly recognise the shortfall in enhancements (similarly for Security), this was funded from the handback of £1.7m from 'SG', and this has been adjusted through to year-end.

Boarding out pressures to date are also funded from the £1.7m.

PAIAW ("Payment as if at work") funding continues to be held as a reserve for the current year, and released monthly to match actual cost.
This continues to be a significant element for the Board regarding our high levels of nursing overtime and vacancies.
Some pressure also remains re prior years' PAIAW still outstanding – with claimants now being in the hand of CLO (and some of whom have been paid.) This has been accrued since March 2022.

In the previous year, some costs of the project works started in 2021/22 re eRostering *(see para 3.2)*, M365 licences, and related pressures – which were accrued to fund an element of anticipated costs in 2022/23 – and from this any unutilised elements have been carried forward to 2023/24. This will need to continue to be accrued since we did not receive additional RRL for either of these projects.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -
Covid-19
Some posts were reviewed for permanency, and a schedule of such posts has been collated and is under consideration.

eRostering Project
While provision was noted for the contractual implementation costs of the eRostering project in 2022/23, this project is now rescheduled nationally by NSS to implement across 2023/24 and 2024/25. Two additional project posts (fixed term) are required in order to manage this implementation. Funding has been secured in 23/24 from RRL and accruals.

Clinical Model review update
Current indications are for the budget for overtime to remain in place, while savings targets have been set at 2% - anticipated from leavers at higher points in the bands' scales being replaced with starters at lower points of the scales.

Energy and inflation increases
The rising costs of energy supplies and the knock-on effect on other supply chain deliverables will continue to be closely monitored as it is expected that there could be significant ongoing pressures.
–Any unused accrual will require to be carried forward to provide against likely pressure in 24/25.

Extra PH for Coronation holiday
It is noted that there is the cost of one day's additional holiday in 2023/24, recurring from 2022/23 (Platinum Jubilee) for the Coronation holiday.

Benefits
Travel underspend has resulted in budgets being reduced in 2023/24, to reflect changed ways of working.

Developments
Some of the development budget (£1.7m AFC RRL) has been released to offset against the nursing pressure, with additional SG budget secured from the noted £1.7m.

3.3 2024/25 Budget

The 2024/25 budget template required by SG has been submitted, including revised savings requirements of £1.3m / approx.3%, with forecast outturn breakeven.

Individual directorate budget reviews are well underway, establishing detailed plans for the achievement of a satisfactory level of savings being identified as recurring for the start of the year, to be reported in future budget submissions. A Board meeting in April will alert members to planned savings in 2024/25.

Estate and energy cost increases are anticipated in the coming year due to market price increases, and pressures are noted for taking forward of new posts and structures established through Covid.

Capital budget for 2023/24 remains at a recurring level of £269k.
Additional project funding will be required 2024/25. Details on capital, refer to section 5. below.

3.4 Year-to-date position 2023/24 – allocated by Board Function / Directorate

Directorates	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	Variance (budget less actuals) for period	Budget WTE	Actual WTE
Nursing And Ahp's	24,301	24,301	24,746	(446)	403.08	410.47
Security And Facilities	6,745	6,745	6,779	(34)	123.82	119.54
Utilities	732	732	739	(7)	0.00	0.00
Medical	3,457	3,457	3,258	198	22.75	16.87
Chief Exec	2,368	2,368	2,257	111	26.07	24.84
Human Resources Directorate	1,100	1,100	1,127	(27)	16.30	17.67
Finance	3,122	3,122	3,361	(238)	29.18	32.66
Cap Charges	2,868	2,868	2,506	361	0.00	0.00
Misc Income	(200)	(200)	(220)	20	0.00	0.00
Central Reserves	954	954	876	78	(1.00)	0.00
	45,446	**45,446**	**45,431**	**16**	**620.20**	**622.05**

Nursing & AHP's

- Ward Nursing annual budgets were revised in December, as noted in 3.1.
  Unutilised central reserves have been phased Apr – Sept offsetting earlier overspends.
  Large numbers of vacancies means that backfill is being covered by overtime.
  Staff usage greater than establishment is mainly due to boarding out, which is now being funded in part, any other variance will be a pressure.

- Psychology vacancies have been significantly high which helps offset some of the ward nursing overspend.

- PAIAW and overtime reserves released monthly.

Security & Facilities & Utilities

- Accruals brought forward are contributing to funding the electricity and biomass pressures.

- There are remaining covid pressures for disposable items being used for patient food delivery, also food price increases are causing pressure in the kitchen and staff restaurant.

- Security annual enhancements shortfall in base budgets now funded from £1.7m.

Medical

- More Consultant time is being recharged for external work; post base budget setting, giving rise to a considerable favourable variance, some of which offsets new Consultant costs.

CE

- Benefit is noted from vacancy management.

HR

- HWL had a new post causing a pressure – budget has now been identified 2022/25.

Finance

- eHealth strategic RRL - there was still a shortfall in funding to address pressures, coupled with unachieved savings.
- Year-end provisions (Injury benefits, pensions, etc.) have hit Finance codes with an anticipated reduction to RRL increasing the hit.

Capital Charges

- Impairment input March – RRL adjustment awaited, also NBV write off hit.

Miscellaneous Income

- The budget recognises income billed for exceptional circumstance patients, with appropriate risk provision for older balances with boards with whom recoverable balances are being discussed.

Central reserves

- These were initially phased to Month 12 (March 2024) – much of which has been released to offset the ward nursing overspend as noted above, hence the currently large balance reduced proportionately as the year progressed.
- Apprenticeship levy is journalled to revenue at year-end.

4 ASSESSMENT – SAVINGS

Savings targets are phased evenly over the year (twelfths), and equate to approx. £0.8m (2%).

Cumulative Savings	Savings - Annual Target	Achieved to date	(under)/over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(39)	44	5
Finance	(57)	25	(32)
Nursing & AHP's	(440)	600	160
Human Resources	(25)	10	(15)
Medical	(65)	10	(55)
Security & Facilities	(140)	84	(56)
Total	**(766)**	**773**	**7**

It should be noted that of the Hospital's budget only 15% of costs are non-pay related, certain boards also treat vacancy savings, or a proportion thereof, as recurring savings, we still class as non-recurring. Savings are slightly overachieved, not quite in the way it was planned, more was achieved through vacancies.

National Boards Contribution

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. The recurring level of contribution to the collective £15m savings challenge remained at £0.220m, and is now reflected in the base allocation for 2023/24.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation is £0.269m, with capital projects planned and agreed through the Capital Group. It is recognised that certain future projects likely to require requests on a project-by-project basis to SG for additional funding will require to be placed "on hold" until it is known when such national resource may be available. Fleet decarbonisation CRL received and spent.

With regard to the Perimeter Security Project allocation, there are elements of delays in the Project – now expected to be completing in 2024/25 Q1. CRL may be amended to match spend.

CAPITAL CRL 2023/2024 AS AT MARCH 2024	ANNUAL PLAN £'k	YTD SPEND £'k
SECURITAS TECHNOLOGY LTD (v Stanley)		73
THOMSON GRAY LTD		193
TSH STAFFING		174
BRICK & STEEL		51
PERIMETER SECURITY TOTAL	**522**	**492**
IM&T		121
OTHER		147
CAPITAL CRL	**269**	**268**
Fleet Decarbonisation / other	**46**	**46**
Total CRL	**837**	**806**

6 RECOMMENDATION

The Board is asked to note the following position and forecast –

Revenue
The year to date position is an underspend of £0.015m. Forecast for the year remains for a breakeven position to be achieved, with year-end savings target also on track.

Capital
Spend ended up marginally below plan, with perimeter project CRL potentially to be reduced to match expenditure.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 10
Sponsoring Director:	Medical Director
Author(s):	PA to Medical Director
Title of Report:	Bed Capacity within The State Hospital and Forensic Network
Purpose of Report	For Noting

1 SITUATION

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

2 BACKGROUND

a) TSH

The following table outlines the high level position from the 1 February 2024 until 31 March 2024.

Table 1

	Admissions & Acute	Treatment & Recovery	Transitions	ID	Total
Bed complement	24	48	24	24 (includes 12 contingency beds)	120 (+ 20 additional unstaffed beds)
Beds in use	17	45	21	12 + 2 surge	97
Admissions	5 (external) 0 (internal)	0 (external) 2 (internal)	0 (external) 3 (internal)	0 (external) 0 (internal)	5 (external) 5 (internal)
Discharges/Transfers	2 (external) 2 (internal)	1 (external) 3 (internal)	4 (external) 0 (internal)	1 (external) 0 (internal)	8 (external) 5 (internal)
Bed occupancy as at 31/03/2024	71%	94%	87.5%	58.3% (all beds) 117% (ID beds)	80.8% (available beds)

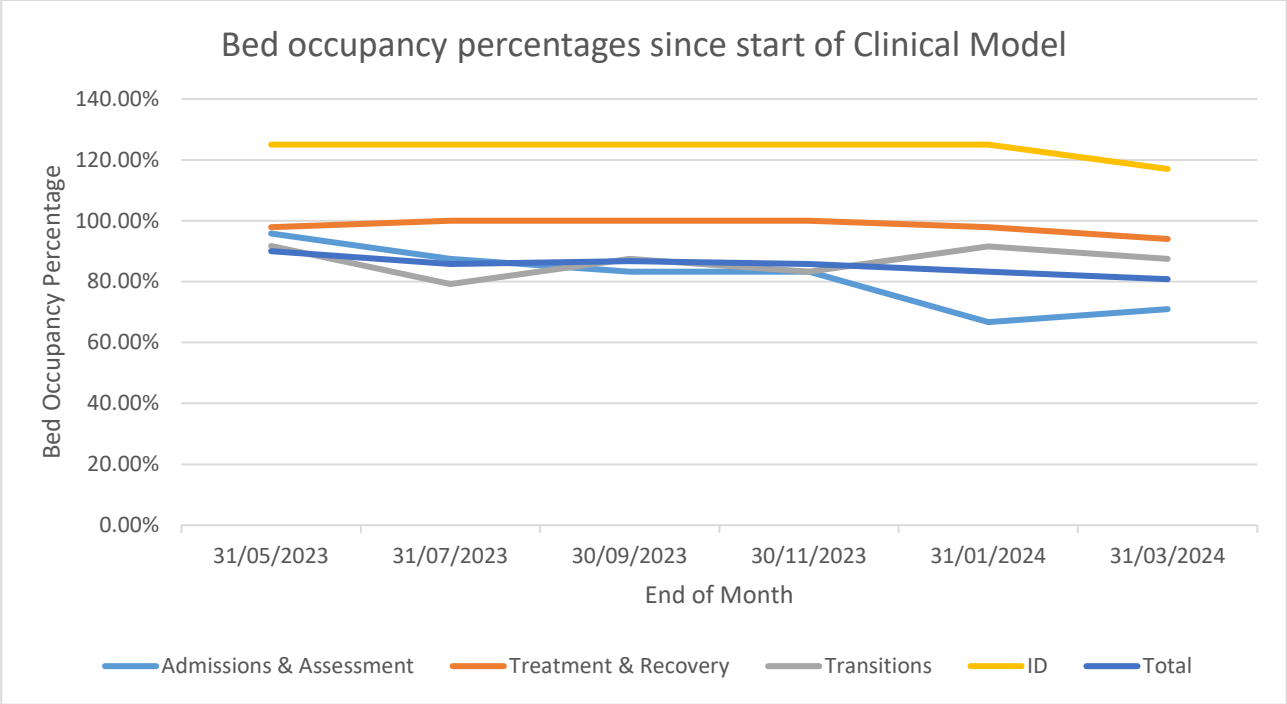
					69.3% (all beds)

Please note that in total there were 97 patients as of 31st March 2024, within this number 14 patients are under the care of the Intellectual Disability Service (the service is currently 2 patients in excess of their 12 patient allocation).

11 identified for transfer, 7 fully accepted, none waiting longer than 8 months and 4 excess appeals won. Full details are available but not included for reasons of patient confidentiality.

There are no patients at TSH under the Exceptional Circumstances clause.

b) Bed Occupancy since start of new Clinical Model



Service	31/05/2023	31/07/2023	30/09/2023	30/11/2023	31/01/2024	31/03/2024
Admissions & Assessment	95.80%	87.50%	83.30%	83.30%	66.70%	71%
Treatment & Recovery	97.90%	100%	100%	100%	97.90%	94%
Transitions	91.70%	79.20%	87.50%	83.30%	91.60%	87.50%
ID	125%	125%	125%	125%	125%	117%
Total	90%	85.8%	86.7%	85.8%	83.3%	80.8%

c) TSH Contingency Plan

Following the new Clinical Model being implemented, a SOP for surge bed contingency planning has been agreed through the Clinical Model Oversight Group. Currently this contingency plan has not been required for patients with major mental illness.

.

d) Forensic Network Capacity

The Board received copies of the Forensic Network's short-, medium- and long-term plans to improve capacity across the forensic estate. These were requested by Scottish Government. We receive a weekly forensic estate update report from the Forensic Network to aid patient flow. The Orchard Clinic has temporarily reduced its capacity by 7 beds for urgent repairs. The Forensic Network at the request of Scottish Government has submitted updated capacity reports of the whole forensic estate and for women in February 2024.

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3 ASSESSMENT

The current bed situation within TSH is manageable The new clinical model is working and there is patient movement between services. More patients are now being discharged from the transitions service. We continue to have surge beds available should we need to move to our bed contingency plan. It is recognised that there is a natural variation in the number of referrals and admissions and we are impacted by capacity in lower levels of security.

4 RECOMMENDATION

The Board is asked to note the report.

MONITORING FORM

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

Paper No: 24/24

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Performance Corporate Planning Support Manager Clinical Quality Facilitators
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1. SITUATION

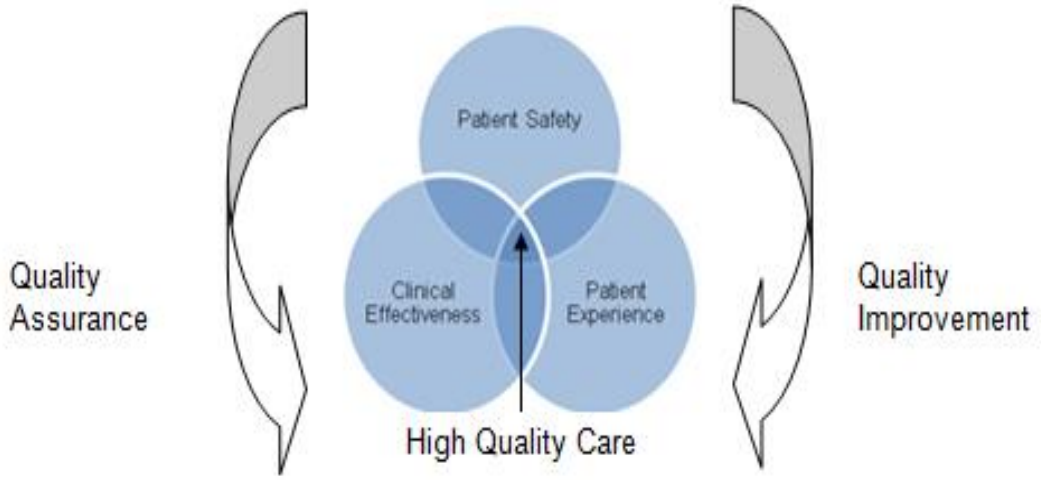
This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in February 2024. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational learning and development. It contributes to the strategic intention of The State Hospital (TSH) to embed quality assurance and improvement as part of how care and services are planned and delivered.

2. BACKGROUND

Quality assurance and improvement in TSH links to the Clinical Quality Strategy 2017 – 2020. The Clinical Quality Strategy is currently being updated and revised, with a Board development session planned for the 2nd May 2024. The current Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. It outlines the following seven goals to ensure the organisation remains focussed on delivering our quality vision:

1) Setting and delivering ambitious quality goals to support the provision of high quality care and services to patients and carers
2) Engaging staff, patients, carers, volunteers and other stakeholders in improving 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 care
5) Ensuring access to and understanding of improvement data to build a positive momentum in relation to quality improvement
6) Evaluating and disseminating our results
7) Building improvement knowledge, skills and capacity

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



3. ASSESSMENT

The paper outlines key areas of activity in relation to:

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

4. RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The quality improvement and assurance report supports the Quality Strategy and Corporate Objectives by outlining the actions taken across the hospital to support QA and QI.
Workforce Implications	Workforce implications in relation to further training that may be required for staff where policies are not being adhered to.
Financial Implications	Not formally assessed for this paper.
Route to Board (Which groups were involved in contributing to the paper and recommendations)	This paper reports directly to the Board. It is shared with the QI Forum
Risk Assessment (Outline any significant risks and associated mitigation)	The main risk to the organisation is where audits show clinicians are not following evidence based practice.
Assessment of Impact on Stakeholder Experience	It is hoped that the positive outcomes with the service level reports will have a positive impact on stakeholder experience as they bring attention to provision of timetable sessions.
Equality Impact Assessment	All the policies that are audited and included within the quality assurance section have been equality impact assessed. All larger QI projects are also equality impact assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	This will be part of the project teamwork for any of the QI projects within the report.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

QUALITY ASSURANCE AND IMPROVEMENT IN TSH APRIL 2024

ASSURANCE OF QUALITY

Clinical Audit

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

There have been 2 audits completed and actioned during this reporting period.

- Medication Trolley Audit
- T2/T3 Audit Report

Medication Trolley Audit
Following disappointing results for this audit in 2023, a new process was implemented whereby the medicine nurse signs to say that they have checked the medication trolley after each medication round to ensure it meets the required standards (historically this was only checked on the night shift).

The re-audit showed that all wards, with the exception of one, had reached excellent compliance with the standard of keeping medication in dose and alphabetical order. The Medicines Committee asked for the wards to celebrate these improvements. The ward that had not met the standard had also not implemented the new process. This has now been actioned.

T2/T3 Audit
Overall, there was good compliance found with these standards.

Recommendations that were approved by the Medicines Committee from this audit to improve compliance further were:

- Remind Medical Staff of Mental Health Act Code of Practice for completing T2 forms
- Process for completing Consent to Treatment forms (T2/T3) to be included in the new trainees induction. This should highlight the T2 proforma which highlights the following requirements in the Mental Health Act Code of Practice:
  1. Has the class or classes of drug been recorded from the BNF?
  2. Has the British approved name been used if naming a specific drug?
  3. Has the route of administration been noted?
  4. Has the dosage and frequency been detailed?
  5. Are all regular psychotropic medications on prescription sheet covered on consent to treatment form?
  6. If patient is on Clozapine is it documented by name along with associated blood tests
- Ensure copy of most recent consent to treatment form is held in the treatment room folder (this is also a recommendation from MWC)
- Ensure medical staff alert the Medical Secretary when a new consent to treatment form has been produced.

These actions will be taken forward by members of the Medicines Committee.

Variance Analysis Tool (VAT) – Flash Reports

The most recent flash report was circulated in March 2024 and covers the month of February:

HOSPITAL WIDE VARIANCE ANALYSIS FLASH REPORT

Date: February 2024

Overview and areas of good practice

This report refers to all annual and intermediate reviews held across the hospital in February 24.

The monthly VAT report is split as follows:

February 24	Annual	Intermediate	Total	VAT completion	MDT attendance
Admission	1	1	2	100%	81% increased from 71% in Jan
Arran T & R	0	5	5	99%	Decreased from 73% in Jan to 66% in Feb
Lewis T & R	1	2	3	98%	Decreased from 72% in Jan to 54% in Feb
ID	1	1	1	100%	Decreased from 75% in Jan to 69% in Feb
Transition	2	3	5	97%	Decreased from 75% in Jan to 65% in Feb

In addition data on individual Admission CPA and Discharge CPA's will be reported to the appropriate service.

VAT completion remained at 98% and all graphs showed random variation.

- Nursing – All BEST and PECC assessments were carried out and all nursing reports were provided.
- Occupational Therapy – Improvements in all OT interventions with the exception of attendance.
- Provision of all Social Work reports and Child Protection Summaries remained at 100% for the 9th consecutive month.
- Provision of the Security reports remained at 100% for the 3rd consecutive month. Attendance still showing random variation due to annual leave and staff staff shifts.
- Provision of the Pharmacy report remained at 100% for the 3rd consecutive month and attendance increased from 39% to 59%.

Areas of concern

- Medical - PANSS assessment decreased from 33% to 13% - they were only carried out in the Transition Service and on 1 occasion it was noted that the informant questionairre was not completed. The issue is that there are 2 components to the PANSS: a medical interview and an informant questionnaire. Both are required for scoring. Completion of the later is problematic and the MD and AND are currently addressing this issue. Nursing – KW/AW attendance decreased from 62% to 59%. Nursing attendance was 100% overall.

- Occupational Therapy – attendance decreased from 77% to 59% due in the main to annual leave (3) and sick leave (2).
- Dietetics – Decrease in all Dietetic interventions. Attendance decreased from 78% to 40% - staff annual leave (1), No reason (1) and VAT not completed (1).
- Psychology – On 1 occasion on Iona the Psychology report was not provided due to staff not being available.
- Skye Avtivity Centre – On 1 occasion in Lewis T & R service the SAC report was not provided due to an administrative error
- Discussion of the report with the patient prior to the review decreased from 77% to 71% - there was also a decrease in the correct use of RiO sub-headings for this intervention from 54% to 53%. Discussion with the patient after the meeting decreased from 100% to 94% - there was an increase in the correct use of RiO subheadings for this intervention from 54% 71%. Going forward the VAT data will have to be collected from RiO due to the risks to the organisation in using the current system. Therefore it is imperative that this process becomes embedded to accurately collect this data.The new process pulls data from specific sub-headings in RiO. The first stage of this is to run a pilot in nursing where the following data is collected using both the exisiting VAT process and the new RiO process:
    - discussing the nursing report with the patient prior to the review
    - discussing the review with the patient after the review

	Aug 23		Sep 23		Oct 23		Nov 23		Dec 23		Jan 24		Feb 24	
	VAT form	RiO – sub head	VAT form	RiO – sub head	VAT form	RiO – sub head	VAT form	RiO – sub head	VAT form	RiO – sub head	VAT form	RiO – sub head	VAT form	RiO – sub head
Pre CPA – Nursing Patient Discussion – progress note sub heading	77%	35%	69%	31%	57%	43%	62%	29%	100 %	75%	77%	54%	71%	53%
Post CPA – Nursing Patient Discussion – progress note sub heading	77%	59%	75%	75%	86%	50%	86%	52%	100 %	87.5 %	100 %	54%	94%	71%

Any challenges with the systems that are being addressed
Ongoing VAT review looking into obtaining assurance data direct from RiO. Pharmacy report template now completed and testing will begin on pulling VAT interventions directly from this report. Work continues with the e-health information team on profession reports and RiO sub-headings in order to allow collection of VAT data direct from RiO.

QUALITY IMPROVEMENT

QI Forum

The QI Forum's purpose is to champion, support and lead quality improvement initiatives across the hospital and raise awareness and understanding of quality improvement (QI) approaches. The QI Forum met recently and has a focus to raise awareness and build capacity to support and embed QI. Over this quarter there are currently a total of 16 QI projects being undertaken throughout the organisation.

QI Capacity Building

Qi Essential Training Cohort 2; Third session is due to be delivered later in the month of April, whereby participants of the course will present their outcome posters which will be displayed in the Notice Board within the Reception area and Staff Wellbeing Centre in Q1 of 2024-25.

Scottish Improvement Leaders (ScIL) Programme: Two members of TSH staff are currently working through the modules in cohort 46-47 ScIL Programme.

The Scottish Coaching and Leading for Improvement Programme (SCLIP): One member of TSH staff was successful in obtaining a place on the next funded SCLIP course.

Managing Quality in Complex Systems Programme: Two members of TSH Staff have been successfully in obtaining 1 space each on Cohort 1 & 2 of the Managing Quality in Complex Systems. Cohort 1 will commence in April 2024and Cohort 2 will commence in October 2024.

Realistic Medicine

Realistic Medicine (RM) is the Chief Medical Officer (CMO) strategy for sustaining and improving the NHS in Scotland. It is the CMO's vision that, by 2025, all healthcare professionals in Scotland will demonstrate their professionalism through the approaches of RM. In December 2022, Scottish Government published "Delivering Value Based Health and Care" (VBH+C), setting out the vision for VBH+C and reinforcing the RM approach as the vehicle through which VBH+C would be realised.

The six key themes of RM are:

- Building a personalised approach to care
- Changing our style to shared decision making
- Reducing harm and waste
- Becoming improvers and innovators
- Reducing unwarranted variation in practice and outcomes
- Managing risk better

The Realistic Medicine Action Plan for 2024/25 was submitted to the Scottish Government on the 15th March (Appendix 1). Scottish Government is hosting a national conference on Realistic Medicine on 22nd April, TSH staff will be in attendance and any learning from this will be shared with colleagues.

A new Project Manager has been appointed and took up post in February.

Evidence for Quality

National and local evidence based guidelines and standards

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

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies and reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 February to 31 March 2024, 26 guidance documents have been reviewed. There were 18 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 8 documents which were recorded for information and awareness purposes; six of which are pending review by various groups regarding the need for circulation for information or matrix completion purposes.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	2	2 (1 TBA)	0
SIGN	1	(1 TBA)	0
Scottish Government	1	(1 TBA)	0
National Institute for Health & Care Excellence (NICE)	22	4 (3 TBA)	0

There are currently 4 additional evaluation matrices, which have been outstanding for a prolonged period and await review by their allocated Steering Group. The progress of the first two evaluations (1 from HIS re Observation to Intervention and 1 from the MWC re seclusion) were temporarily paused due to TSH adapting to the COVID-19 pandemic, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group, which recommenced meetings in September 2020. Work is nearing completion with both, with an agreed launch date of May 2024.

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

The fourth and final evaluation matrix for SIGN national guideline for stroke was delayed due to prioritizing of numerous guideline reviews by the practice nurse and GP. It should be noted that there are approximately 530 recommendations within this document which required to be reviewed given that only a limited number may be relevant to TSH. An adapted evaluation matrix has been compiled for review and availability is being sought to arrange completion by a wider multi-disciplinary group.

Table 3: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
HIS	From Observation to Intervention: A proactive, responsive & personalised care	Patient Safety	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Finalising of evaluation matrix in progress further to Clinical Care policy	Jan 2019	May 2024

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
	& treatment framework for acutely unwell people in mental health care		approval by PAG and go live date of May 2024.		
MWC	The use of seclusion	Patient Safety	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Care Policy with seclusion tier 1 and 2 being incorporated. Both policies to be launched together. Finalising of evaluation matrix in progress further to Clinical Care policy approval by PAG. Go live date of May 2024.	Oct 2019	May 2024
NICE	Multiple sclerosis in adults: Management UPDATED	PHSG	Previously reviewed in Oct 2014 when recorded for information purposes only. Given that TSH had no patients with an MS diagnosis PHSG agreed that should this change, the guideline would be used. Current 2022 situation was same however there is now a possible diagnosis pending with patient on waiting list for further investigation. Completion of matrix placed on hold until outcome of referral.	June 2022	2024 Awaiting outcome from specialist referral (July 2023)
SIGN	National Clinical Guideline for Stroke	PHSG	CQ and Practice Nurse met to review content as it contains over 530 recommendations which will not all be relevant to TSH. Meetings held and identification of relevant recommendations complete. Document collated and review meeting being scheduled involving all disciplines for final completion.	April 2023	July 2024

Paper No: 24/24

Appendix 1

Table 1: TSH Action Plan 2024-25

Commitment 1 - Continue to Promote Realistic Medicine							
Department/ Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Action for 2024-25**	**Realistic Medicine Link**
Communications	Engagement and Awareness of Realistic Medicine within VBH&C	All	RM clinical lead	2018	Ongoing	Staff bulletins twice annually. Seminar Series twice annually Presentations at staff development. Flash Report post on the intranet. Evidence based Realistic Medicine summary. Realistic Medicine Intranet Page.	-Shared Decision Making -Personalised Approach to Care -Reduce Harm and Waste -Reduced Unwarranted Variation -Manage Risk Better -Become Improvers and Innovators

Commitment 2 - Promote the Measurements of Outcomes							
Department/ Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Actions for 2024-25**	**Realistic Medicine Link**
Research and Development	Clinical Outcomes Monitoring Process: More effective engagement of frontline clinical staff in utilising the wide range of available data to inform and support clinical decision-making.	All	R & D Manager	2020	Ongoing	Clinical Quality staff have been aligned with the new Service Leadership Teams in for each clinical service in 2023 to support the use of data to inform clinical decision making and improvement. This change in practice will be monitored over 2024/25 and improvements made to support use of data for clinical decision making. TSH has progressed a project on global functional outcome measurement to determine the progress, or otherwise, of patients. The Mental Health Practice Steering Group (MHPSG) have been piloting two outcome measures in 2023/24, one in Arran Hub – The FORUM - and one in Mull Hub – the Clinical Global Impression (CGI) Scale. The former is a longer questionnaire but encompasses both self-report by patients and team-report – this has demonstrated preliminary benefits in being able to pick up change and discrepancies between team and self-views on progress. The CGI is a brief snapshot type instrument using only team-report.	-Personalised Approach to Care -Reduce Harm and Waste -Reduce Unwarranted Variation

						A report on the Outcome Tool pilot that has been conducted in Arran and Mull hubs will be submitted to the March MHPSG meeting, addressing data generated through use of the tools and qualitative feedback from clinicians involved in their completion. Following this the MHPSG will consider next steps in progressing outcome measurement.	

Commitment 3 - Continue to Support the Development of Tools							
Department/ Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Actions for 2024-25**	**Realistic Medicine Link**
Physical Health Steering Group	To review the process for completing Nutritional and Physical Health Care checklists in line with National Food, Fluid & Nutrition Standards.	All	Frances Waddell Karen Burnett Hannah McAllister Andrew Service Tracy Tait	Jul-21	Ongoing	TSH is in the process of rolling out Nutrition & Physical Health Care Checklists. This new checklist has streamlined reporting and is being introduced using QI methodology to test change idea to ensure that the change is sustaining before implementing further. Plan for 2024/25 is to continue to review outcome data, using pareto charts and run charts to analysis data with a staggered implementation across 10 wards using “what work well” and “even better if” approaches.	-Reduce Harm and Waste -Reduced Unwarranted Variation
Admission SLT (Clinical Model)	There will be a cohesive, multidisciplinary decision-making process around the provision of activity within 14 days for patients admitted to TSH.	All	Admission SLT	Being discussed at the February 2024 meeting	Being discussed at the February 2024 meeting	Activity is a core aspect of patient care. The develop a multidisciplinary activity plan for newly admitted patients will support a structured approach for patients to engage in activity This a project will develop 2024/25	-Shared Decision Making -Personalised Approach to Care -Reduce Harm and Waste -Reduced Unwarranted Variation -Become Improvers and Innovators
Mental Health Practice Steering Group	CPA Process Review	All	MHPSG	2022	Ongoing	The aim of the CPA process review is to support a more co-productive approach to all aspects of CPA care planning. The MHPSG have made a number of changes to the CPA document to improve the process refocusing the document to be more patient centered and link with outcomes. The MHPSG are currently consulting with internal and external stakeholders including the MWC, MHTS and Restricted Patients’ Team. The aim is to test the new process April – June 24 and have completed by Dec 24.	-Personalised Approach to Care -Reduce Unwarranted Variation -Manage Risk Better

Mental Health Practice Steering Group	Pre-admission Specific Needs Form: Ongoing Development	All	MHPSG	Apr-22	Ongoing	Further improves in this process are being looked at as part of the admission process working group. This links to developments in referral processes and will connect with the Referral Policy.	-Personalised Approach to Care -Reduce Unwarranted Variation
Realistic Medicines Nursing	BRAN Questions	Arran Hub	Michelle McKinlay	Dec 23	April 24	The use of BRAN questions to foster shared decision-making and patient engagement has been introduced as part of the monthly care plan reviews. A QI project was established in Dec 2023 in 1 hub to support key workers to use BRAN questions when updating the Nutritional & Physical Health Care Planning. Posters were developed for staff and patients to explain the approach and guidance was developed for staff. This guidance has been updated to reflect TSH examples of good practice. Uptake is monitored on a monthly basis with staff in the wards being supported by RM project team. To improve uptake, link nurses for each ward have been identified. Action in 2024/25 will be to continue to monitor through testing phase and embedding through the hospital by stagged implementation. Work with patients and carers on the benefits of BRAN questions will also continue. This links also with the SDM module on Turas	Personalised Approach to Care Manage Risk Better Shared Decision Making

Commitment 4 - Continue to Build a Community of Practice							
Department/ Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Actions for 2024-25**	**Realistic Medicine Link**
Qi Forum	Monitor the number of QI initiatives in place under a TSH365 model when compared to success of TSH3030.	Quality Improvement	QI Forum	2021	Ongoing	To QI Forum is a multidisciplinary Forum that meets every 6 weeks to support and progress QI initiatives and capacity building for QI across TSH. A QI Projects data base has been developed to provide an overview of QI projects and support teams when necessary. Support for capacity building will continue and consideration in 2024/25 to run a further TSH 30:30 style event aligned with organisational priorities	-Become Improvers and Innovators
Quality Improvement	QI Training	All	QI Forum	March 24	Dec 24	Linking in with the QI Forum capacity building for QI will continue with a plan to deliver 1 x Qi Essential Training over 2024/25 and continue to support staff to participate in ScIL & ScLIP	-Become Improvers and Innovators

Learning into Practice (LiP)	LiP Meetings and System: providing multidisciplinary staff with a process to identify, share, reflect and discuss experiences and generate learning and change ideas from their practice.	All	RM Clinical lead	March 24	Ongoing	TSH has continued to consider improvements to a process to share and reflect on experiences to generate learning. Current approach is to introduce a service led, team based quality review (TBQR) approach. Guidance has been redrafted using new approach. Service led teams are being identified. Regular LiP Team meetings are being scheduled Take new TBQR LiP proposal through Patient Safety Group. Identify service based LiP Panels. Deliver TBQR training for key staff. Support services to start local TBQR processes. Convene hospital wide biannual LiP Fora.	-Reduce Harm and Waste -Manage Risk Better -Become Improvers and Innovators
The Forensic Network	Continuous Quality Improvement Framework Reviews (CQIF)22	All	Forensic Network Manager	2022	2025	The Network to review their project plans prior to engaging with local services and embarking upon an implementation visit phase, in order to ensure an appropriate level of resource is available to support the next round of reviews.	-Reduced Unwarranted Variation

Commitment 5 - Support Delivery of Sustainable Care							
Department/ Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Actions for 2024-25**	**Realistic Medicine Link**
Practice Development	Clinical Supervision	All	Hannah McAllister	Dec-22	Ongoing	Clinical Supervision will be implemented nationally and will include a national NHS framework. TSH has been preparing for this change. Training for staff has been delivered. There are QI projects in Lewis and Mull Hubs. Learning from these will feed into wider rollout	-Reduce Harm and Waste -Manage Risk Better

Practice Development	Patient and Staff Debriefs: to ensure that following certain incidents within the hospital that the staff and patients have a meaningful debrief.	Iona Hub	Hannah McAllister	Aug-22	Ongoing	Debriefs following incidents is recognised as good practice. QI projects have been ongoing in TSH in both ID and Admissions service to refine process and develop checklist. Next steps will be to include patient debrief and test template	-Reduce Harm and Waste -Manage Risk Better
Business Support	Development of a New Observation Policy	All	Nursing Practice Development IOP Lead	Apr-21	Jun 24	TSH has been working towards the implementation of our new Clinical Care policy. The new policy will bring a change in practice and an end to the current language used around observation practices and will instead focus on a more person-centred approach to care and risk management. The policy will be supported by the implementation of the Improving Observation Practice framework. Preparatory training around areas such as understanding trauma, the importance of clinical supervision, and the development of person-centred care plans is ongoing. Implementation will be supported with a communications plan to raise awareness across staff groups to this change in practice. The implementing will be monitoring through the Clinical Governance Group. Implementation is planned for Q1/2 of 24/25	-Manage Risk Better -Personalised Approach to Care -Reduced Unwarranted Variation
Clinical Model Oversight Group	Clinical Model Review	All	CMOG	Jul-23	Jul-24	The new Clinical Model was implemented in July 2023. The Clinical Model Oversight Group CMOG plans to review the progress of the model to date in Feb and consider any updates/changes that may be required to the Model. This will be the first review of what will be an iterative process into the medium/long term.	-Manage Risk Better -Personalised Approach to Care -Reduced Unwarranted Variation -Reduce Harm and Waste

Commitment 6 - Engage with the Public to Promote Understanding							
Department/ Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Actions for 2024-25**	**Realistic Medicine Link**
Patient Advocacy Service	Patient Advocacy Service (PAS) Initiatives	All	PAS Manager	Will be agreed following SLA agreement	Will be agreed following SLA agreement	No actions are identified at this time as Service Level Agreement is under review.	-Shared Decision Making -Personalised Approach to Care
Mental Health Practice Steering Group	Advance Statements	All	MHPSG	Jun-22	Ongoing	Advance Statements enable a co-produced description of patients wishes for care when they are unable to engage due to deterioration of health. Advance Statement information if currently held in hard copy, however changes to medicines administration to an electronic format, means that there needs to be a change in practice to ensure that Advanced Statements are reviewed at point of medicines administration. The MHPSG will develop a project over 2024/25 to investigate more efficient ways of access patients advance statements at the point of medicine administration.	-Shared Decision Making -Personalised Approach to Care
Realistic Medicine	Shared Decision Making Online Module	All	Learning and Development Department	May 2024	Ongoing	The Shared Decision Making module on TURAS provides staff with an awareness and overview of the principles of Realistic Medicine. TSH has explored ways to increase uptake of this module. In Oct 2023 the SDM module was embedded within the Staff Induction Process and aligned with the BRAN work. Plan for 2024/25 will be to continue to support SDM in induction process and utilise link nurses to promote the importance of completing the on-line module as well as being available to support staff.	-Shared Decision Making -Manage Risk Better -Become Improvers and Innovators

Paper No: 24/25

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 12
Sponsoring Director:	Director of Workforce
Author(s):	HR Advisor / Training & Professional Development Manager / Head of HR
Title of Report:	Staff Governance Report
Purpose of Report:	For Noting

1 SITUATION

This report provides a summary of ongoing activity in relation to key staff governance factors, with particular reference to changes since the last Staff Governance Committee on 15th February 2024.

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

2 BACKGROUND

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

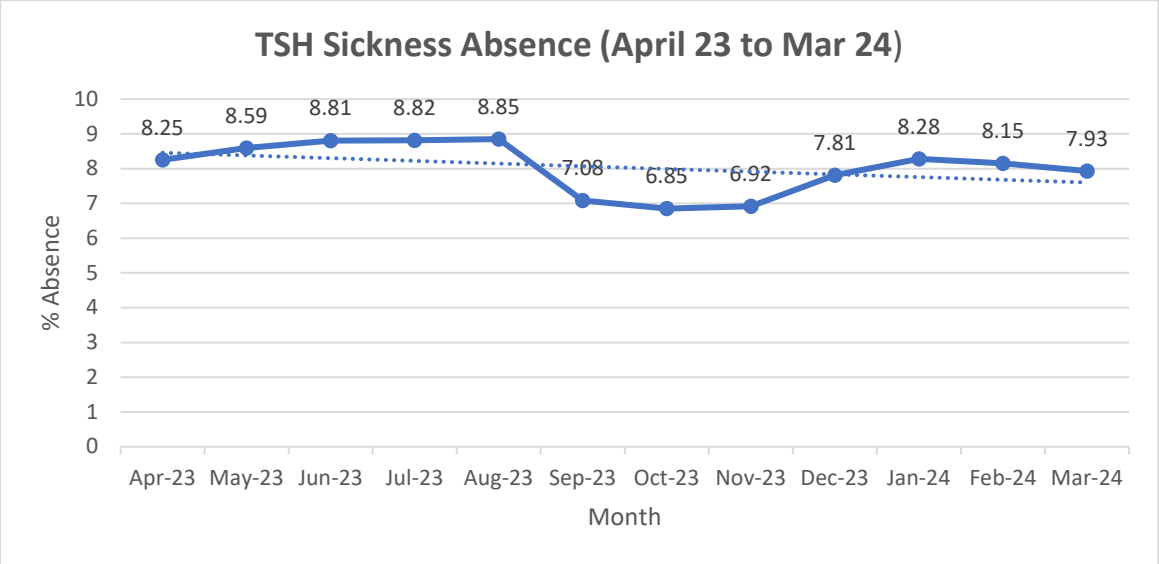
The Teams work closely together to support Managers and Staff within TSH on a number of key areas and this report details the background and update for each Department.

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

3 ASSESSMENT

a) HR UPDATE

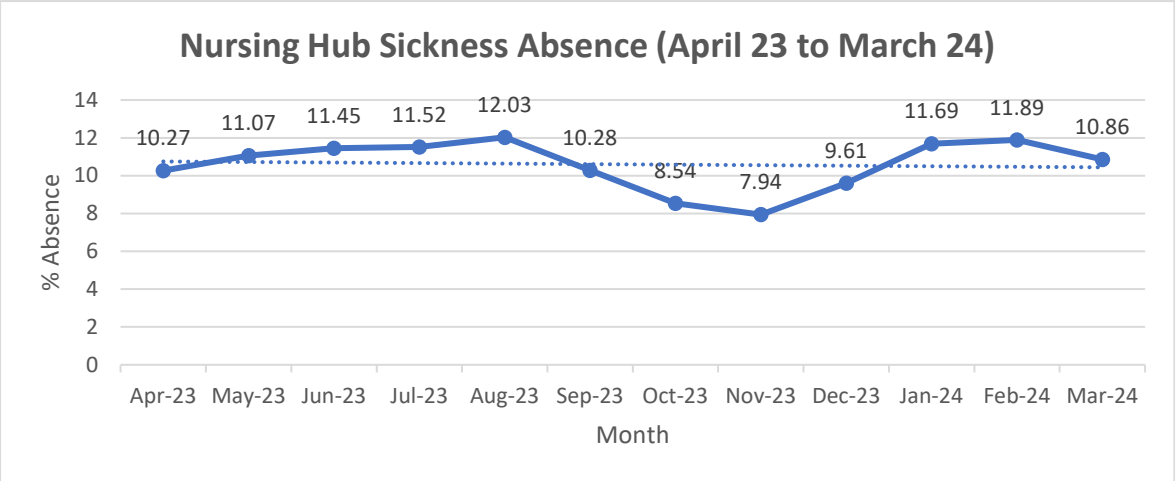
i) Absence and Attendance Management



Our position of 7.93% sickness absence in March 2024, comprised of 5.47% long term and 2.46% short term, highlights: -

- A continued downward trend in sickness absence, particularly in relation to long term sickness.
- Our monthly position is approximately 0.5% higher than our 12 month rolling average.
- Our absence figure remains greater than the NHS Scotland average of 6.10% and the 12 month rolling average of 6.20%

Nursing focus



The Nursing Hub remains a key area of concern in terms of overall absence, however, absence for March 2024 highlights a much improved monthly position reducing by 1.03% to 10.86%, which was comprised of 7.74% long term and 3.12% Short Term.

Absence Reasons

- Key reasons for short-term absence were anxiety/stress/depression, cold/cough/flu, chest / respiratory problems, back problems, injuries/fractures and gastrointestinal.
- Key reasons for long-term absence, were anxiety/stress/depression, musculoskeletal, injury / fracture and back problems.

Key Actions

An absence Task and Finish Group has been meeting fortnightly for over 6 months with a focus on areas in which to improve attendance and to support managers in this process. This approach is now under review, with a key focus being on how we develop and maintain a sustainable and effective approach to attendance management as part of our business as usual approach.

Attendance Management Activity (April 23 to March 24)

Active Monitoring	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Total
2023													
Stage One	9	25	14	14	25	32	19	17	13	11	19	17	215
Stage Two	1	1	2	4	3	2	4	1	1	1	1	2	23
Stage Three	0	0	0	0	0	0	0	0	0	1	0	0	1
Grand Total	10	26	16	18	28	34	23	18	14	13	20	19	239

Staff actively monitored from effective date of monitoring

Training / Support

- *The HR team continue to support line managers and offer guidance around policy compliance and best practice.*
- *Attendance Policy training is continuing to take place for all managers and staff side representatives within the hospital. 38 managers have attended to date and the topics covered in the training include application of the Attendance Policy, absence reporting, holding meaningful absence meetings, return to work discussions, occupational health referrals and employee assistance. Next training session is planned for 30 April 2024 with 16 invites have been sent.*

ii) Recruitment & Retention

- 8 Separate posts were advertised totalling 20 vacancies.
- 12 individuals with confirmed start dates and a further 6 with conditional offers.
- Time to Hire was 83 days, in excess of our KPI of 75 days, with greater focus required on the length of closing dates for posts.
- Alongside planned retirements, secondments and recent recruitments the projected variance will be 11.8 wte Band 5 Registered Nurses and no Band 3 deficits.

- Following the recent recruitment campaign, 4 x Band 5 Registered Nurses are due to start in May. 13 x Band 3 Nursing Assistants also start in May, noting there was agreement to 'over recruit' within the Band 3 to reflect projected leavers within this grade, throughout the year.
- In support of our Employability agenda, the new apprenticeship guidance agreed and Managers are encouraged to review this prior to advertising for appropriate posts to consider the opportunities for their department.

iii) Other Key Indicators

- WTE Supplementary Staff: 58.25 wte for March, increase of 2.36 wte.
- WTE Nursing Supplementary Staff: 36 WTE for March, increase of 3.40 wte.
- Supplementary Staff Register: 13.10 wte for March

Increased clinical activity on site, coupled with higher use of annual leave throughout March has seen this increase in supplementary staff usage.

- Leavers: 4 in month of March (in comparison to 6 in March 23)
- 55 in total for 2023/24 as opposed to 73 in 2022/23
- Exit Interviews: 22 of 5
- 5 have been completed (40%)

iv) Employee Relations

In line with Once for Scotland Policy approach, this table evidences our ongoing commitment to supporting and encouraging early resolution, with matters dealt with informally and at the earliest opportunity, which is very positive.

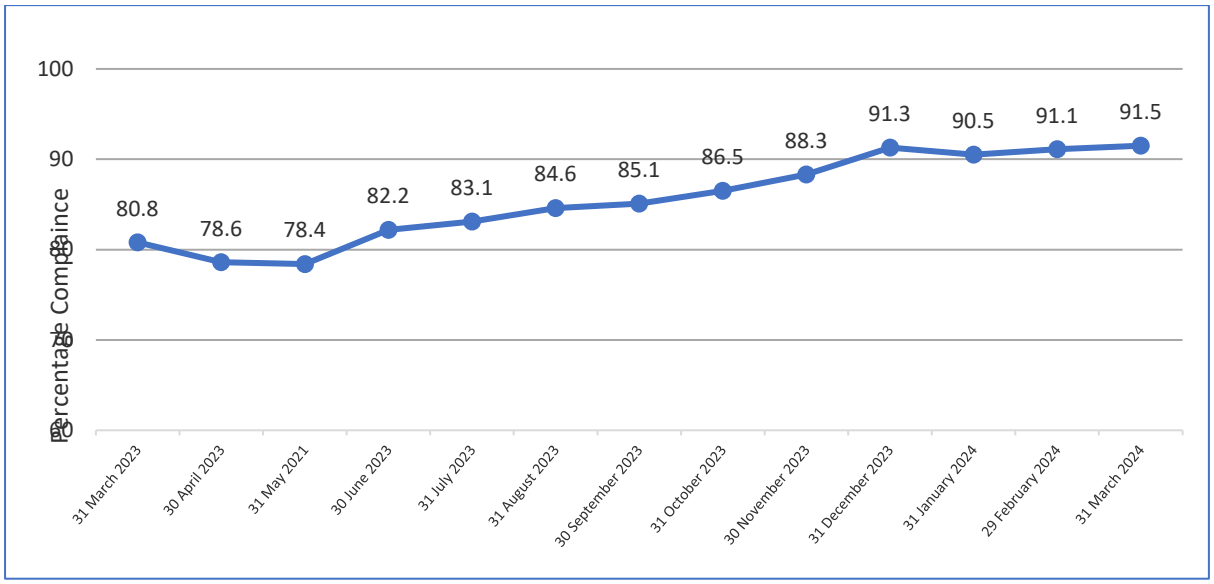
	April 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	March 24
Capability- informal	1	0	0	0	0	2	0	1	1	0	0	0
Capability – formal	0	0	1	0	0	0	0	0	0	0	0	0
Conduct – informal	0	0	0	0	0	1	0	2	1	1	1	2
Conduct – formal	1	3	0	0	1	1	2	1	0	0	2	0
Bullying & Harassment - informal	0	0	0	0	0	0	0	0	0	1	1	0
Bullying & Harassment - formal	0	0	0	0	0	0	0	0	0	0	0	0
Grievance- informal	1	0	0	0	0	0	1	0	1	0	0	0
Grievance - formal	0	0	0	0	0	0	0	0	0	0	0	0
Whistleblowing	0	0	0	0	0	0	0	0	0	0	0	0
Total	3	3	1	0	1	4	3	4	3	1	2	2

b) Learning, Training & Organisational Development

i) PDPR Compliance

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

As at 31 March 2024:



Progress reports continue to be provided to all departmental managers on a monthly basis, and compliance levels are monitored and reviewed quarterly by the Organisational Management Team. Compliance will also be monitored at the Quarterly Performance Reviews with the Chief Executive.

ii) Wellbeing Strategy Evaluation project.

A hospital-wide wellbeing survey subsequently went live on 25 March 2024 and will be open for four weeks (closing on 19 April 2024).

A series of one-to-one interviews will also be conducted to gather data on staffs' 'lived experience' and obtain qualitative feedback on the strategy's impact. Interviews will be conducted with a small, representative sample of the staff population, and will include a mix of both staff who have and have not accessed the wellbeing services.

The survey responses will be analysed using support provided via the Research Manager, and the OD Manager will conduct the thematic analysis of the one-to-one interviews.

Results from this analysis will be supplemented and triangulated with the secondary data sources discussed above to ensure a comprehensive evaluate of the strategy. The data analysis is planned to take place in May, and a report of the findings will be produced by the end of May 2024. The report will be made available to staff, subject to review and approval via the relevant governance structures.

The outputs and recommendations from the Wellbeing Strategy evaluation will be used to inform future wellbeing priorities and interventions. They will also be considered during development of the new OD strategy.

4 RECOMMENDATION

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Nursing and Operations / Director of Workforce
Author(s):	Director of Nursing and Operations/ Senior Nurse Workforce planning
Title of Report:	Implementation for Health and Care Staffing Act/ eRostering Update
Purpose of Report:	For Noting

1 SITUATION

The Health and Care (Staffing) (Scotland) Bill was passed by parliament on 2 May 2019 and received Royal Assent on 6 June 2019 and was enacted on 1 April 2024. All Boards will be required to report on an annual basis regarding their compliance with the legislation, the first report due in April 2025. The purpose of this paper is to ensure that the Board remain sighted on the requirements of the legislation and identify specific actions required to ensure full compliance by April 2025.

2 BACKGROUND

The aim of the Health and Care (Staffing) (Scotland) Act is to provide a statutory basis for the provision of appropriate staffing in health and care service settings, enabling safe and high quality care and improve outcomes for service users. It will do this by ensuring that the right people with the right skills are in the right place at the right time, creating better outcomes for patients and service users and support the wellbeing of staff.

The Act does not seek to prescribe a uniform approach to workload or workforce planning. Instead it enables the development of suitable approaches for different settings. The Act aims to:

- provide assurance that staffing is appropriate to support high quality care, identify where improvements in quality are required and determine where staffing has impacted on quality of care
- support an open and honest culture where clinical/professional staff are engaged in relevant processes and informed about decisions relating to staffing requirements
- enable further improvements in workforce planning by strengthening and enhancing arrangements already in place to support transparency in staffing and employment practice

across Scotland, and through the use of, and outputs from, the Common Staffing Method and associated decision making processes

- ensure the clinical voice is heard at all levels by ensuring arrangements are in place to seek and take appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing, including: identification of risks; mitigation of any such risks, so far as possible; notification of decisions and the reasons why to record any disagreement with the decision made

3 ASSESSMENT

All territorial Health Boards and those National Health Boards delivering patient facing clinical services are covered by the legislation, which is underpinned by guiding principles and duties.

The main purposes of staffing for health and care services is to provide safe and high-quality services and to ensure the best health or care outcomes for service users.

Progress to date HCSA

- Submitted Self Assessment report to Scottish Government on the 25/03/2024.
- Progressing with test of change of abridged version of MH workload tool and once outputs from test are analysed then will roll out across remaining wards.
- Multi Disciplinary professional judgement tool was presented to Iona Clinical Team.
- Engagement session has been arranged for the Psychology Team on 04/04/2024. This will be jointly presented by HIS and the Senior Nurse -Workforce Planning. Future sessions will be rolled out to AHP and Medics in Q1 of the new financial year.
- The state Hospital has been identified to take part in an observational study. This will help shape the development of a new Mental Health Learning Disability Workload Tool which will be validated around October 2024. The study is due to commence in April.

Reporting

The State Hospital's Quarter 2 report was submitted to the Scottish Government in November 2023. A formal response providing feedback on this submission was not received until the 19th March. However, informal feedback had provided reassurance we are working positively towards our preparedness for enactment in April 2024. The final Q3 report was submitted in 25th March 2024, SG were advised that the late receipt of the Q2 feedback did not allow us to reflect this in our Q3 report but would be included in the TSH Q1 report. SG have advised that feedback will be verbal from now on.

The table below describes where we have assessed ourselves against each of the duties. You will note we are in a good position and have no areas identified in Red. A robust project plan is in place involving all relevant clinicians. The continued progress will be monitored monthly via the Health and Care Staffing Act Compliance Group.

Duty	Duty Title	Current Picture
121A	Duty to ensure appropriate staffing	Substantial Assurance
121C	Duty to have real-time staffing assessment in place	Reasonable Assurance
121D	Duty to have risk escalation process in place	Substantial Assurance
121E	Duty to have arrangements to address severe and recurrent risks	Substantial Assurance
121F	Duty to seek clinical advice on staffing	Reasonable Assurance
121H	Duty to ensure adequate time given to clinical leaders	Reasonable Assurance
121I	Duty to ensure appropriate staffing: training of staff	Substantial Assurance
121J	Duty to follow common staffing method	Reasonable Assurance
121L	Training and Consultation of staff	Reasonable Assurance
N/A	Planning and securing services	Substantial Assurance

Our first annual report to SG on compliance of the legislation will be in April 2025.

Progress to date eRostering

1. **Health Roster**

There are 41 roster locations within Optima Health roster and 36 rosters are live in using the system.

Some outstanding national system issues which are well known and reported previously, work continues to resolve these. There are also local practice issue which we are working through to support the full realization of the benefits of the e-rostering system.

Continues to progress with the following:

- Safecare
- Employee Online
- Employee Online

Project Support
The Project Manager and Project Officer posts have both been extended to 30 June 2024 in which time the focus will be to establish BAU processes.

Next Steps
Group now focusing on the remaining actions prior to end of project in 3 months' time and integrating this work into existing process and fora as we move to BAU.

4 RECOMMENDATION

The state Hospital's Board for Scotland is invited to note the content and the ongoing work on progress of work to date.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Act links closely to the overall clinical and staff governance objectives within TSH.
Workforce Implications	As detailed within the Paper
Financial Implications	This is likely to have financial implications however it is difficult to quantify the levels currently.
Route to Committee Which groups were involved in contributing to the paper and recommendations.	Board Staff Governance Workforce Governance Group
Risk Assessment (Outline any significant risks and associated mitigation)	Unknown currently
Assessment of Impact on Stakeholder Experience	As detailed within Paper
Equality Impact Assessment	
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick (✓) One; ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Paper No: 24/27

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 14
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Quarter 4 Update and Whistleblowing Standard Annual Report – 2023/24
Purpose of Report:	For Decision

1 SITUATION

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

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

2 BACKGROUND

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

3 ASSESSMENT

The Quarter 4 update is from 1 January 2024 to 31 March 2024. No formal Whistleblowing cases were raised during this quarter either direct to The State Hospital or indirect via the INWO.

In the performance year 2023/24, the State Hospitals Board for Scotland had no cases raised under Whistleblowing. This Annual Report details the work undertaken to develop the established processes within the Board, and supportive speak up culture, within our Action Plan.

4 RECOMMENDATION

Members of the Board are asked to approve the Whistleblowing Annual Report for 2023/24 which will be sent to the INWO and published on the Internet site.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

WHISTLEBLOWING ANNUAL REPORT

1 April 2023 to 31 March 2024

1. INTRODUCTION

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

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

In addition to this, the Scottish Government revised and promoted the role of the Whistleblowing Champion as a formal Non-Executive member of each NHS Board, with our appointment finalised in December 2022. Their role is to ensure that the systems are in place to enable staff to raise concerns, and that the culture of the organisation supports the full application of these systems, by valuing staff concerns.

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

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

This is the third Annual Report and is for the reporting activity from 1 April 2023 until 31 March 2024.

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

2. BACKGROUND

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

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

A Whistleblowing Action Plan was developed by the HR & Wellbeing Group and is reported to Partnership Forum, Corporate Management Team, Staff Governance Committee and the Board. This action plan will now be overseen by the Workforce, Wellbeing & OD Delivery Group who will co-ordinate and support implementation of the Action Plan, ensuring HR policy and process implementation, training and communications are fully met.

Delivery of this Action Plan is fully supported by all members of the Board who play a role in ensuring communication and development of the action in line with the Standard.

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

A collective and proactive approach has been taken in engaging with the organisation and raising awareness of the Standards whilst the Whistleblowing Champion is in post to provide critical oversight of governance mechanisms for reporting on and dealing with Whistleblowing concerns, to complement the oversight provided by the Board.

3. CONCERNS RAISED

Since 1 April 2023 to 31 March 2024 there was no Whistleblowing concerns raised direct to the Board.

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

4. ACTIONS

The State Hospital have recently met with INWO and are in the process of further review of both our actions to date and also how we can continue to develop and improve our overall approach to whistleblowing and a 'Speak Up' Culture.

Key themes which have been considered are:

- Review of Recruitment Processes;
- Work on building key relationships to ensure openness and transparency;
- Improving general communications on the Whistleblowing Standards and Training;
- Improving general communication on Speak Up.
- Refresh of the approach to Confidential Contacts;
- Review of an internal Operating Procedure providing clarity on the process followed when dealing with any concerns;
- Additional support sources, not only for those who are raising the concerns but for anyone who may become involved (i.e. witnesses)

These learning points form part of the Action Plan, and will be considered at the Workforce, Wellbeing and OD Delivery Group and updated to the Staff Governance Committee and Board.

The State Hospital participated in the "Speak up Week" which took place on 2-6 October 2023. Staff Bulletins were circulated to the service with updates from a number of contributors including the Chair, Chief Executive and Employee Director. Noticeboards provided information to staff on the Standard and the main one was placed in the front reception area.

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

Introduction for all Staff – 518 (96% of target group)
Managers Training – 88 (85% of target group)

5. FUTURE ACTIONS

Work continues to refine our approach and ensuring continued areas of improvement, which include:

- Refresh of approach to Confidential Contacts, which includes discussions with other National Boards to support this agenda, ensuring complete confidentiality and independence at all stages.

- Clarity and continued development of the Standard Operating Procedure. This Operating Procedure would provide clarity regarding how a Whistleblowing complaint will be dealt with from initial receipt until the closure of a case, the sharing of lessons learned, and service improvements made as a result of a concern being raised.

- Alignment of whistleblowing and Speak Up culture with our programmed OD activity during 2024/25.

6. REPORTING

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

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

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

27 April 2023	-	Quarter 4 update for 1 January to 31 March 2023 and Whistleblowing Standard Annual Report-2022/23
24 August 2023	-	Quarter 1 update, 1 April to 30 June 2023
21 December 2023	-	Quarter 2 update, 1 July to 30 September 2023
22 February 2024	-	Quarter 3 update, 1 October to 31 December 2023
25 April 2024	-	Quarter 4 Update, 1 January to 31 March 2024

7. QUALITY AND PATIENT CARE

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

8. CONCLUSION

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

The State Hospitals Board for Scotland
12 April 2024

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 15a
Sponsoring Director:	Finance & eHealth Director
Author(s):	Finance & eHealth Director
Title of Report:	Annual Review of Standing Documentation
Purpose of Report:	For review and approval

1 SITUATION

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

2 BACKGROUND

The Audit and Risk Committee is required to review and to make recommendations to the Board in regards to changes to Standing Documentation i.e. Standing Financial Instructions, Scheme of Delegation and Standing Orders (covered under a separate Committee paper).

3 ASSESSMENT

3.1 Standing Financial Instructions

There are three amendments noted –

- Updated Director titles (Workforce, Nursing and Operations, Security Estates and Resilience)
- Updated s6.4.9 reflective of recommended practice
- Updated references to “Audit Committee” to state “Audit and Risk Committee”.

No other amendments are noted. These were fully updated in 2022 to reflect updated legislation and procurement regulations post-EU, updated tender thresholds to comply with Procurement Act 2014, updated tender waivers from £5k to £10k (last update 2016) and updated TSH Procurement Policy.

3.2 Scheme of Delegation

There are three amendments noted –

- Updated s14.1 to note the approval required should the Board at any time require annual spend in excess of SG budget allocation *(as requested by Audit & Risk Committee, March 2024)*
- Updated Director titles (Workforce, Nursing and Operations, Security Estates and Resilience)
- Updated references to "Audit Committee" to state "Audit and Risk Committee".

There are no other amendments noted nor required.

4 RECOMMENDATION

Members are asked to approve the review of Standing Documentation, as approved by the Audit & Risk Committee at its meeting on 21 March.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Ensures that the Board's standing documentation is up to date in respect of Scottish Government guidance and possible changes to Senior staff's portfolios.
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Finance & eHealth Director, Head of Procurement, Deputy Finance Director, Senior Financial Accountant
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ **There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

SCHEME OF DELEGATION

VERSION 18

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

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

17	April 2023	Amended section 14.9 to clarify inclusion of SLAs Removed historic reference to sealing of documents Approved by Audit Committee 6 April 2023 For approval by Board 27 April 2023
18	April 2024	Insertion of new clause 14.1 re approval of expenditure in excess of SG annual allocation Updated Director titles (Nursing & Operations, Workforce, Security Estates and Resilience) Approved by Audit and Risk Committee 21 March 2024 For approval by Board 25 April 2024

1. DELEGATION OF POWERS

1.1 Delegation to Committees

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

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

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

2. SCHEME OF DELEGATION TO OFFICERS

2.1 Role of the Chief Executive

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

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

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

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

2.2 Caution over the Use of Delegated Powers

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

2.3 Directors' Ability to Delegate their own Delegated Powers

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

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

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

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

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

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

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

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

	SFI Reference	Delegated to	Duties Delegated
	1.1.5	FD	Approval of all financial procedures.
	1.3.9	CE	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
	1.3.10	FD	Responsible for implementing the Board's financial policies and co-ordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
	1.3.10	FD	Maintaining an effective system of internal financial control
	1.3.10	FD	Ensuring that sufficient records are maintained to show and explain the Board's transactions
	1.3.14	ALL DIRECTORS AND EMPLOYEES	Ensuring that the form in which financial records are kept and the manner in which directors and employees discharge their duties is to the satisfaction of the Director of Finance and eHealth.
	3.1.1	CE	Submit to the Board an annual strategic plan (currently "Annual Delivery Plan"- formerly "Remobilisation Plan" 2021-2023 and "Annual Operational Plan" to 2020) covering 3 year period.
	3.1.2 & 3.1.3	FD	Submit budgets to Board and monitor performance against budget and strategic plan.
	3.2	CE	Delegate management of budgets to budget holders.
	3.3	FD	Devise and maintain systems of budgetary control.
	3.3	FD	Deliver adequate training on an ongoing basis to budget holders to enable them to manage effectively.
	3.4	CE	Identifying and implementing cost improvements and income generation initiatives.
	3.6	CE	Ensuring that the required financial performance returns are submitted to the SGHSCD.
	4	FD	Prepare annual accounts, financial returns and supporting papers
	5.1	FD	Managing the Board's banking arrangements
	6.1	FD	Designing, maintaining and ensuring compliance with income systems.
	7.1	CE	Capital programme investment process, and scheme of delegation for capital investment management.
	7.1.4	FD	Procedures for the regular reporting of expenditure and commitment, including reporting to the Board.

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

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

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

THE STATE HOSPITALS BOARD FOR SCOTLAND
SCHEME OF DELEGATION

1. Organisational Scope / Profile

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
1.1 Preparation and Maintenance of Service Directory	Chief Executive	Director of Nursing & Operations ("Director of Nursing")	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	Dierctor of Finance & EHealth ("Finance Director")	N/A	CG & RM standards, SG standards, Governance Statement

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	Person Centred Improvement Lead	N/A	CG & RM Standards

4. Planning and Performance

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

5. Risk Management

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

6. Clinical Governance

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

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
6.5 Complaints				
Responding to complaints	Chief Executive	Deputy Chief Executive	N/A	Complaints guidance
Maintenance of complaints procedures and reporting	Finance Director	Head of Corporate Planning & Business Support	N/A	Complaints guidance
6.6 Knowledge Services	Director of Nursing	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	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	N/A	N/A	
Advocacy	Director of Nursing	N/A	N/A	
Carers	Director of Nursing	Person Centred Improvement Lead	N/A	
Volunteering	Director of Nursing	Person Centred Improvement Lead	N/A	
Spiritual and Pastoral Care	Director of Nursing	Person Centred Improvement Lead	N/A	
Patient and Carer Information and Communications	Director of Nursing	Person Centred Improvement Lead	N/A	

8. Access, transfer, referral, discharge

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
8.1 Monitoring of Waiting Times				
- Psychological Therapies	Medical Director	N/A	N/A	Delivery Plan
- Patient Activity and Recreational Services	Director of Nursing	N/A	N/A	Delivery Plan
8.2 Public Information on access to services	Director of Nursing	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	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	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	N/A	as per financial plan	CG & RM Standards
10.2 Public Health Information dissemination	Director of Nursing	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 Director of Workforce	Head of eHealth Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.5 Freedom of Information Act	Finance Director	Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.6 Caldicott Guardian	Medical Director	Associate Medical Director	N/A	CG & RM Standards Information Governance Standards

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

12. Staff Governance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
12.1 Staff Governance Standards				
Implementation of Staff Governance Standards action plan	Director of Workforce	N/A	N/A	Staff Governance Standards
HR policies and procedures	Director of Workforce	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	Director of Workforce	N/A	N/A	SGHSCD guidance
12.3 Workforce Planning	Director of Workforce	N/A	N/A	SGHSCD guidance
12.4 Contracts of employment	Director of Workforce	N/A	N/A	Staff Governance Standards PIN guidelines
12.5 Systems for Professional registration and CPD	Medical Director & Director of Nursing	N/A	N/A	CG & RM Standards
12.6 Learning and Development Plans	Director of Workforce	N/A	N/A	Staff Governance Standards Development Plan
12.7 Whistleblowing Policy	Director of Workforce	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 Director of Workforce	N/A	N/A	
b) Appeal against disciplinary action short of dismissal	Manager of Disciplinary decision maker	N/A	N/A	Subject to no involvement in disciplinary action
c) Appeal against disciplinary action short of dismissal (action taken by Director)	Chief Executive	N/A	N/A	
d) Appeal against disciplinary action short of dismissal (action taken by Chief Executive)	Staff Governance Committee	N/A	N/A	
e) Appeal against dismissal	Chief Executive	N/A	N/A	
f) Appeal against disciplinary action in respect of Directors	Remuneration Committee	N/A	N/A	
g) Appeal against disciplinary action in respect of the Chief Executive	Full Board or special Committee with delegated authority	N/A	N/A	Subject to members not having been involved in disciplinary action
12.9 Senior Employees Remuneration				
Remuneration and performance of Directors and Senior Managers	Remuneration Committee	N/A	N/A	SGHSCD guidance

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

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

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

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

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.1 Authority to commit expenditure in excess of SG annual budget allocation	Board	Chief Executive	-	
14.2 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	
14.3 Virement of Budget within approved Resource Limit for items where no provision has been made in approved plans/ budgets	Chief Executive	Finance Director	£100k	
14.4 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	Dep'y Director of Finance		
d) achievement of savings	Directors Chief Executive	Named Deputies	Savings notified	

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
e) Virement of Budget between Directors				Subject to maximum virement limit of Chief Executive
- per event up to £25,000	Directors	Named Deputies	< £25k	
- per event over £25,000 and up to £100,000 annually	Chief Executive	Finance Director	> £25k < £100k	
f) Virement of Budget between Directors				
- non recurring	Finance Director	N/A	< £100k	
-recurring	Chief Executive	N/A	< £100k	
14.5 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	
14.6 Setting of Fees and Charges	Finance Director	N/A	N/A	
14.7 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	
14.8 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
	Head of Procurement (PO only)	Procurement Team Leader, Deputy Director of Finance, Finance Director (PO only)		
c) Annual Value over £15,000 and up to £20,000	Finance Director	Chief Exec, Deputy Chief Exec	>£15k < £20k	Subject to containment within overall Board resources
	Head of Procurement (PO only)	Procurement Team Leader, Deputy Director of Finance, Finance Director (PO only)		

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

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

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

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

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

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

STANDING FINANCIAL INSTRUCTIONS

VERSION 20

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

14	March 18	Updated section 2.6.2 to reflect depute Accountable Officer as being Nursing & AHP Director and not Finance Director. Updated section 3.6 to change Monitoring Returns to Financial Performance Returns. Updated section 5 in relation to Project Bank Accounts. Updated section 9.6 to reflect that payments to employees would be by bank credit only. Updated section 13.1.1 to include reference to General Data Protection Regulations. Updated section 16.1.10 to include new rules imposed in October 2017 around patient gambling. Approved by Audit Committee 5 April 2018. Approved by Board 28 June 2018
15	March, May 2019	Updated references to Local Delivery Plan – amended to Annual Operational Plan Updated section 5.3.2 – reflect requirement of two directors' signed authorisation to open any bank account in the name of the Hospital Removed section 17 – Funds held in Trust – no longer applicable to the Hospital with no endowment funds in place Approved by Audit Committee 28 March 2019. Approved by Board 20 June 2019
16	March 2020	Amended wording re secondment of HR Director (1.3.15) Approved by Audit Committee 26 March 2020 Approved by Board 18 June 2020
17	March 2021	Updated references to Annual Operational Plan – amended to Remobilisation Plan Updated job titles Approved by Audit Committee 25 March 2021 Approved by Board 17 June 2021
18	March 2022	Updated sections 10.2.7, 10.3.2 – removing EU reference, update re new Procurement Regulations Updated section 10.3.4,5 – update tender thresholds to comply with Procurement Act 2014, tender waiver from £5k to £10k (last update 2016) Updated section 10.3.10 – re new TSH Procurement Policy Updated section 10.4.1 – re new legislation Approved by Audit Committee 17 March 2022 Approved by Board 23 June 2022
19	March 2023	Updated section 6.2.3 – updated job title Approved by Audit Committee 6 April 2023 Approved by Board 27 April 2023
20	April 2024	References to Audit Committee amended to Audit and Risk Committee Director titles updated (Workforce, Security Estates and Resilience, Nursing and Operations) Updated section 6.4.9 – reflective of recommended practice Approved by Audit and Risk Committee 21 March 2024 For approval by Board 25 April 2024

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1 INTRODUCTION

1.1 General

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

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

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

1.1.4 Statutory Instrument (1974) No 468 requires NHSScotland Finance Directors to design, implement and supervise systems of financial control and NHS Circular 1974 (Gen) 88 requires the Hospital's Director of Finance and EHealth 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 Director of Finance and EHealth must approve all financial procedures. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance and EHealth 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, Director of Finance and EHealth, 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 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" (Standing Orders Section 20 a)).

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

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

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

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

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

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

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

1.3.10 The Director of Finance and EHealth 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 Director of Finance and eHealth include:

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

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

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

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

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

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

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

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

2 RESPONSIBILITIES OF CHIEF EXECUTIVE AS ACCOUNTABLE OFFICER

2.1 Introduction

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

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

2.2 General Responsibilities

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

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

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

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

2.3 Specific Responsibilities

2.3.1 The Accountable Officer must:

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

- Ensure that the assets for which he/she is responsible, such as land, buildings or

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

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

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

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

2.4 Advice to the Body

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

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

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

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

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

2.5 Appearance before the Public Audit Committee

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

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

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

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

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

2.6 Absence of Accountable Officer

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

2.6.2 In the event of the Accountable Officer not being available the Director of Nursing & Operations 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and eHealth'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 Director of Finance and EHealth.

3.3.4 The Director of Finance and EHealth 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 Director of Finance and EHealth, on behalf of the Board, will:

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

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

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

4.1.5 The Board's audited annual accounts must be presented to a public meeting, not later than 6 months after the Board's accounting date. The audited annual accounts shall not be presented until the Audit and Risk 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth shall authorise the opening of an account in the name of The State Hospital, for which signed authority will be required by the Director of Finance and EHealth and one other executive director.

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

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

6.1 Income Systems

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

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

6.3 Debt Recovery

6.3.1 The Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth, and suitable receipts obtained. The loss of any key shall be reported immediately to the Director of Finance and EHealth. The Director of Finance and EHealth, on receipt of a satisfactory explanation, shall authorise the release of the duplicate key. The Director of Finance and EHealth shall arrange for all new safe keys to be dispatched directly to him/her from the manufacturers. The Director of Finance and EHealth shall be responsible for maintaining a register of authorised holders of safe keys.

6.4.3 The Director of Finance and EHealth 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 Director of Finance and EHealth.

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 It is recommended that any large sums of cash collected for unofficial purposes (e.g. for retirements, leavers) should not be retained at ward / department level. Such funds should, if preferred, be considered for passing to the finance department for safe keeping. Once the collection is complete the cash can then be returned to the collector.

7 CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

7.1 Capital Investment

7.1.1 The Chief Executive:

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

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

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

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

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

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

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

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

7.2.4 The Director of Finance and EHealth 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 Director of Finance and EHealth. 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 Director of Finance and EHealth 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 Director of Finance and EHealth.

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 Director of Finance and EHealth 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 Director of Finance and EHealth is notified of the disposal of any such assets
c) All proceeds from the disposal of such assets are notified to the Director of Finance and EHealth.

8 SERVICE LEVEL AGREEMENTS (SLAs)

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

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

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

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

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

9 TERMS OF SERVICE AND PAYMENT OF EXECUTIVE DIRECTORS AND EMPLOYEES

9.1 Remuneration and Terms of Service

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

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

9.1.3 The Remuneration Committee will:

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

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

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

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

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

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

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

9.2 Funded Establishment

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

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

9.3 Staff Appointments

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

a) Unless given delegated authority to do so by the Chief Executive
b) Within the limit of his/her approved budget and funded establishment
c) In accordance with procedures approved by the Director of Workforce.
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 Director of Finance and EHealth or his/her delegated officer, before appointment.

9.4 Contracts of Employment

9.4.1 The Director of Workforce 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 Director of Workforce 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 Director of Finance and EHealth.

9.6 Processing of Payroll

9.6.1 The Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Workforce'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 Director of Workforce must be informed immediately.

9.7 Settlement Agreements, Early Retirement and Redundancy

9.7.1 The Director of Workforce, jointly with the Director of Finance and EHealth 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 Director of Workforce 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 Director of Workforce 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth, 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 Director of Finance and EHealth, 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth
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 Director of Finance and EHealth and that:

a) All contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance and EHealth in advance of any commitment being made
b) Contracts above specified thresholds are advertised and awarded in accordance with WTO GPA rules on public procurement and comply with the Public Contracts (Scotland) Regulations 2015 and the Procurement Reform Act Scotland 2014
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 Director of Finance and EHealth (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 Director of Finance and EHealth 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 Director of Finance and EHealth (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 Director of Finance and EHealth
m) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance and EHealth
n) Purchases via Purchasing Cards are in accordance with instructions issued by the Director of Finance and EHealth
o) Petty cash records are maintained in a form as determined by the Director of Finance and EHealth.

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 Public Contracts (Scotland) Regulations 2015 and the Procurement Reform Act Scotland 2014procedures 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 £50,000 or greater (exclusive of VAT), a regulated tender process will be carried out. Where the estimated value of the contract is between £5,000 and £50,000 a quotation proces will be carried out and both processes will cover:

- 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 the Director of Security, Estates and Resilience is required)or
f) As provided for in the Scottish Capital Investment Manual.
g) The overall value of the contract exceeds £10,000 + VAT.

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

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

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

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

10.3.10 Tendering procedures are set out in a separate Procurement Policy for Tendering and Contracting.

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 (per Scheme of Delegation 14.10).

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 Director of Finance and EHealth.

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) WTO GPA Directives and other statutory provisions
d) Any relevant directions including the Scottish Capital Investment Manual and guidance on the Use of Management Consultants (MEL(1994)4)
e) Such of the NHS Standard Contract Conditions as are applicable
f) Public Contracts (Scotland) Regulations 2015
g) Procurement Reform Act Scotland 2014

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

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

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

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

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

10.4.6 The Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth. The control of Pharmaceutical stocks shall be the responsibility of a nominated pharmaceutical officer; the control of fuel oil and bio-fuel of a designated facilities manager.

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

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

11.1.4 The Director of Finance and EHealth 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 Director of Finance and EHealth.

11.1.6 The nominated managers shall be responsible for a system approved by the Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 and Risk 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 Director of Finance and EHealth shall ensure that appropriate insurance arrangements exist in accordance with the risk management programme.

13 INFORMATION TECHNOLOGY

13.1.1 The Director of Finance and EHealth 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 Director of Finance and EHealth
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 Director of Finance and EHealth 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 Director of Finance and EHealth:

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

14 AUDIT

14.1 Audit and Risk Committee

14.1.1 In accordance with Standing Orders the Board shall formally establish an Audit and Risk 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 and Risk Committee is satisfied there is evidence of ultra vires transactions, evidence of improper acts, or any other issue, the Chair of the Audit and Risk 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 and Risk Committee with the guidance of the Director of Finance and EHealth to ensure that both an effective and cost effective internal audit service is provided. The Director of Finance and EHealth will retender Internal Audit services at least every five years. The Review panel will include the Chairman of the Audit and Risk Committee, the Chief Executive and the Director of Finance and EHealth and may also include other members of the Audit and Risk Committee. Tendering will be done on the basis of Technical ability, a Qualitative assessment and affordability.

14.2 Director of Finance and eHealth

14.2.1 The Director of Finance and EHealth 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 and Risk Committee
f) Ensuring that the Chief Internal Auditor prepares a detailed operational plan each financial year for approval by the Audit and Risk 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 and Risk Committee, for the consideration of the Audit and Risk 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 Director of Finance and EHealth 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 Director of Finance and EHealth must be notified immediately.

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

14.3.5 The Chief Internal Auditor shall be accountable to the Director of Finance and EHealth. The reporting and follow-up systems for internal audit shall be agreed between the Director of Finance and EHealth, the Audit and Risk 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 Standards. 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 and Risk 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 and Risk 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 and Risk 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth
b) Recorded by the relevant officer, in a form approved by the Director of Finance and EHealth, 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 Director of Finance and EHealth.
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 Director of Finance and EHealth who will take the appropriate action.

15.1.4 The Director of Security Estates and Resilience 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 Director of Finance and EHealth 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 and Risk Committee, shall review the Summary of Losses and Special Payments which shall be prepared by the Director of Finance and EHealth 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

15.2.4 The Director of Finance and EHealth 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 Director of Finance and EHealth should consider whether any insurance claim can be made.

15.2.6 The Board shall delegate to the Chief Executive and the Director of Finance and EHealth, 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 Director of Finance and EHealth shall maintain a Losses and Special Payments Register in which write-off action is recorded – which shall be reviewed on an annual basis.

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

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

15.3.1 The Director of Finance and EHealth 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 Director of Finance and EHealth will be the nominated contact for the National Fraud Initiative (NFI) and will authorise the release of the required data for this purpose. The Director of Finance and EHealth may delegate the NFI investigation and reporting requirements, to suitable representatives. The Director of Finance and EHealth 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 Director of Finance and EHealth, 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 Director of Finance and EHealth 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 and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth 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 Director of Finance and EHealth'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 Director of Security Estates and Resilience 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 Director of Finance and EHealth.

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 Director of Finance and EHealth.

16.1.6 Staff should be informed, on appointment, formally in writing by the Director of Workforce 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 Director of Finance and EHealth 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 and Risk Committee annually.

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

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

17 RETENTION OF DOCUMENTS

17.1.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in SHM 58/60, NHS MEL (1993)152 “Guidance for the Retention and Destruction of Health Records” and HDL (2006) 28 “The Management, Retention and Disposal of Administrative Records”, The Scottish Government records management: NHS code of practice (Scotland) version 2.1: 11 January 2012.

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

17.1.3 Documents held under the above guidance shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

18 STANDARDS OF BUSINESS CONDUCT

18.1 General Responsibility

18.1.1 It shall be the responsibility of the Chief Executive to:

- Ensure that the Scottish Government Health and Social Care Directorate guidelines on standards of business conduct for NHS staff (MEL (1994) 48) are brought to the attention of all staff, and effectively implemented
- Develop local policies and the processes to implement them, in consultation with staff and local staff representatives
- Ensure that such policies are kept up to date.

18.1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000 provides a code of conduct for members of The State Hospitals Board for Scotland. This code was incorporated into Board Standing Orders in May 2003. The principles that apply to gifts and hospitality set out in Standing Orders (Section 3) apply equally to all staff and Board members.

18.2 Acceptance of Gifts and Hospitality

18.2.1 The acceptance of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Corruption Acts 1906 and 1916. In the event of a contractor or other supplier of goods or services making such an offer to any officer, either for their personal benefit or the "benefit" of the Board, the guidance given in HSG(93)5 and NHS Circular HDL (2003) 62 (or subsequent guidance issued by the Scottish Government Health and Social Care Department) must be followed. Initially, the matter must be reported to an individual's line manager, or the relevant Director. Acceptance, or refusal, of gifts or hospitality must be entered in a Register of Hospitality and Interests, which will be maintained by the Director of Finance and EHealth. 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 officer's line manager before accepting.
c) Visits at supplier's expense to inspect equipment etc should not be undertaken without the prior approval of the Chief Executive and in the case of the Chief Executive by the prior approval of the Chairman. Costs associated with such visits will be borne by The State Hospital.
d) If officers are involved in the acquisition of goods and services they should adhere to the ethical code of the Institute of Purchasing and Supply.
e) Officers should ensure that the acceptance of commercial sponsorship will not influence or jeopardise purchasing decisions.

18.3 Private Transactions

18.3.1 Where offers of goods or services do not involve inducement or reward, employees should still not accept gifts from commercial sources other than inexpensive articles such as calendars or diaries. If any such gifts should arrive unsolicited, the advice of the Director of Finance and EHealth should be sought.

18.4 Declaration of Interest

18.4.1 Employees having official dealings with contractors and other suppliers of goods or services should avoid transacting any kind of private business with them by means other than normal commercial channels. No favour or preference as regards price or otherwise which is not generally available should be sought or accepted.

18.4.2 In accordance with Standing Order 5, the Chief Executive shall be advised of declared pecuniary interests of Directors or senior staff for recording in the Register of Hospitality and Interests.

18.4.3 The Director of Finance and EHealth 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 and Risk 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

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 15b
Sponsoring Director:	Audit and Risk Committee Chair
Author(s):	Head of Corporate Governance/Board Secretary
Title of Report:	Annual Review of Standing Orders and Code of Conduct
Purpose of Report:	For Decision

1 SITUATION

On 21 March 2024, the Audit and Risk Committee reviewed the Board's Standing Orders as well as Members Code of Conduct as part of the annual review of standing documentation.

2 BACKGROUND

The Audit and Risk Committee is required conduct this review of standing documentation, and to make its recommendations to the Board on this basis.

3 ASSESSMENT

The Board Standing Orders were fully updated in 2020 in line with NHS national guidance and prescribed formatting, and review has not highlighted any areas that require change. There are no further amendments proposed at a national level.

The Members Code of Conduct are based on the principles of Section 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000. It should be noted that the Standards Commission recently revised their Guidance on the Councillors' Code, following Ethical Standards Commissioner's investigations and at findings at Hearings. The Standards Commission has made making similar changes to their Guidance on the Model Code for Members of Devolved Public Bodies. Whilst this does not indicate any change to the Members Code of Conduct, the following should be noted in terms of the additional guidance provided by the commission,

The key points are:

- more information and examples about when the applicable Members' Code could apply;
- information about how the Standards Commission will make an objective assessment when deciding whether alleged conduct could amount to a breach of the respect, courtesy, bullying or harassment provisions in the Code;
- a note advising that anyone can make a complaint to the Ethical Standards Commissioner about an alleged breach of the Code and that pressurising employees to do so could compromise their position;

- a note advising that ignoring training on the Code could be an aggravating factor in terms of the sanction, should a breach of it then be found;
- more information about what might constitute registrable Category 5: Houses, Land and Buildings interest; and
- more information about what might constitute a registrable Category 8: non-financial interest.

In respect of the Model Code the following guidance has been added:

- the composition of boards and the complaint route for different types of board members; and
- the requirement for members to act in the best interests of the public body, as opposed to the interests of any individual constituency from which they have been appointed, nominated or elected.

4 RECOMMENDATION

The Board is asked to approve the review of the Standing Orders and Members Code of Conduct and to confirm that no amendments are required.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives?	Ensures that the Board's standing orders and members code of conduct are up to date in respect of regulatory guidance and
Workforce Implications	None identified as part of this reporting
Financial Implications	None identified as part of this reporting
Route to the Board Which groups were involved in contributing to the paper and recommendations?	Required as part of annual review of standing documentation
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ **There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

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

1 General

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

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

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

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

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

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

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

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

Board Members – Ethical Conduct

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

the Register, he or she must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

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

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

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

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

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

2 Chair

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

3 Vice-Chair

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

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

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

4 Calling and Notice of Board Meetings

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

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

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

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

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

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

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

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

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

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

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

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

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

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

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

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

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

Quorum

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

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

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

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

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

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

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

Adjournment

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

Business of the Meeting

The Agenda

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

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

Decision-Making

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

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

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

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

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

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

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

Board Meeting in Private Session

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

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

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

<u>Minutes</u>

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

5.25 The Board's Board Secretary (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft

minutes at the following meeting. The person presiding at that meeting shall sign the approved minute.

6 Matters Reserved for the Board

Introduction

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

6.2 This section summarises the matters reserved to the Board:

a) Standing Orders
b) The establishment and terms of reference of all its committees, and appointment of committee members
c) Organisational Values
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Annual Operational Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Annual Operational Plan, the Board should receive it at a public Board meeting.)
f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Standing Financial Instructions and a Scheme of Delegation.
j) Annual accounts and report. (Note: Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly the Board cannot publish the report of the external auditors of their annual accounts in this period.)
k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment.)

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

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

7 Delegation of Authority by the Board

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

Scheme of Delegation
http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx

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

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

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

8 Execution of Documents

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

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

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

9 Committees

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

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

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

9.4 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a Committee member who is also a non-executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members includes some of the Board's members, the committee's meetings shall not be held in

public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise.. Generally Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However if the committee elects to consider certain items as restricted business, then the meeting papers for those items will normally only be provided to members of that committee. The person presiding the committee meeting may agree to share the meeting papers for restricted business papers with others.

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

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

A MEMBERS' CODE OF CONDUCT

1 Introduction

The Scottish public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties for The State Hospitals Board for Scotland. You must meet those expectations by ensuring that your conduct is above reproach.

The Ethical Standards in Public Life etc. (Scotland) Act 2000 provides for new Codes of Conduct for local authority councillors and members of relevant public bodies; imposes on councils and relevant public bodies a duty to help their members to comply with the relevant code; and establishes a Standards Commission for Scotland to oversee the new framework and deal with alleged breaches of the codes.

This Code covers members of The State Hospitals Board for Scotland. As a member of the State Hospitals Board for Scotland, it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct.

Guidance on the Code of Conduct

You must observe the rules of conduct contained in this Code. It is your personal responsibility to comply with these and review regularly, and at least annually, your personal circumstances with this in mind, particularly when your circumstances change. You must not at any time advocate or encourage any action contrary to the Code of Conduct.

The Code has been developed in line with the key principles listed in section 2 and provides additional information on how the principles should be interpreted and applied in practice. No Code can provide for all circumstances and if you are uncertain about how the rules apply, you should seek advice from the Chairperson, or the Chief Executive. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

Enforcement

Section 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 sets out the provisions for dealing with alleged breaches of this Code of Conduct and the sanctions that shall be applied if the Standards Commission finds that there has been a breach of the Code. Those sanctions are outlined in Annex A.

2 Key Principles of the Code of Conduct

The general principles upon which this Model Code of Conduct are based are:

Public Service

You have a duty to act in accordance with the core tasks and in the interests of the State Hospitals Board for Scotland of which you are a member.

Selflessness

You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

Integrity

You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

Objectivity

You must make decisions solely on merit when carrying out public business.

Accountability and Stewardship

You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that the State Hospital uses its resources prudently and in accordance with the law.

Openness

You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands, or in the interests of patient confidentiality.

Honesty

You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

You have a duty to promote and support these principles by leadership and example, to maintain and strengthen the public's trust and confidence in the integrity of the State Hospitals Board for Scotland and its members in conducting public business.

Respect

You must respect fellow members and employees of the State Hospital and the role they play, treating them with courtesy at all times.

You should apply the principles of this Code to your dealings with fellow members of the State Hospitals Board for Scotland and its employees.

3 General Conduct

Relationships with Employees of the State Hospital

You will treat any staff employed by the State Hospital with courtesy and respect. It is expected that employees will show you the same consideration in return.

Allowances

You must comply with any rules of the State Hospital regarding remuneration, allowances and expenses.

Gifts and Hospitality

You must never canvass or seek gifts or hospitality.

You are responsible for your decisions connected with the offer or acceptance of gifts or hospitality and for avoiding the risk of damage to public confidence in the State Hospitals Board for Scotland. As a general guide, it is usually appropriate to refuse offers except:

(a) isolated gifts of a trivial character or inexpensive seasonal gifts such as a calendar or diary, or other simple items of office equipment of modest value;

(b) normal hospitality associated with your duties and which would reasonably be regarded as inappropriate to refuse; or

(c) gifts received on behalf of the State Hospitals Board for Scotland.

You must not accept any offer by way of gift or hospitality which could give rise to a reasonable suspicion of influence on your part to show favour, or disadvantage, to any individual or organisation. You should also consider whether there may be any reasonable perception that any gift received by your spouse or co-habitee or by any company in which you have a controlling interest, or by a partnership of which you are a partner, can or would influence your judgement. The term “gift” includes benefits such as relief from indebtedness, loan concessions, or provision of services at a cost below that generally charged to members of the public.

You must not accept repeated hospitality from the same source. You must record details of any gifts and hospitality received and the record must be made available for public inspection.

You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision made by the State Hospitals Board for Scotland may be involved in determining, or who is seeking to do business with your organisation, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit to inspect equipment, vehicles, land or property, then as a general rule you should ensure that the State Hospitals Board for Scotland pays for the costs of these visits.

Confidentiality Requirements

There may be times when you will be required to treat discussions, documents or other information relating to the work of the State Hospitals Board for Scotland in a confidential manner. You will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. There are provisions in legislation on the categories of confidential and exempt information and you must always respect and comply with the requirement to keep such information private.

It is unacceptable to disclose any information to which you have privileged access, for example derived from a confidential document, either orally or in writing. In the case of other documents and information, you are requested to exercise your judgement as to what should or should not be made available to outside bodies or individuals. In any event, such information should never be used for the purpose of personal or financial gain, or used in such a way as to bring the State Hospitals Board for Scotland into disrepute.

Use of Public Body Facilities

Members of the State Hospitals Board for Scotland must not misuse facilities, equipment, stationery, telephony and services, or use them for party political or campaigning activities. Use of such equipment and services, etc must be in accordance with the State Hospitals Board for Scotland policy and rules on their usage.

Appointment to Partner Organisations

You may be appointed, or nominated by the State Hospitals Board for Scotland, as a member of another body or organisation. If so, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body. No NHS body is permitted to nominate a person to be a director of another Company.

4 Registration of Interests

The following paragraphs set out the kinds of interests, financial and otherwise which you have to register. These are called "Registerable Interests". You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in the State Hospitals Board for Scotland Register.

The Board will maintain a formal Register of Members' Interest, which should be available to the public, on request from Corporate Services, at the State Hospital, Carstairs. The Register will include details of all directorships and other relevant and material interests which have been declared by the Chairperson, executive and non-executive Board Directors/Members.

This Code sets out the categories of interests, which you must register. Annex B contains key definitions to help you decide what is required when registering your interests under any particular category. These categories are listed below with explanatory notes designed to help you decide what is required when registering your interests under any particular category.

Category One: Remuneration

You have a Registerable Interest where you receive remuneration by virtue of being:

- employed;
- self-employed;
- the holder of an office;
- a director of an undertaking;
- a partner in a firm; or
- undertaking a trade, profession or vocation or any other work.

The amount of remuneration does not require to be registered and remuneration received as a Member does not have to be registered.

If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two, "Related Undertakings".

If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

When registering employment, you must give the name of the employer, the nature of its business, and the nature of the post held in the organisation.

When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a partnership, you must give the name of the partnership and the nature of its business.

Where you undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if you write for a newspaper, you must give the name of the publication, and the frequency of articles for which you are paid.

When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and the nature of its business.

Registration of a pension is not required as this falls outside the scope of the category.

Category Two: Related Undertakings

You must register any directorships held which are themselves not remunerated but where the company (or other undertaking) in question is a subsidiary of, or a parent of, a company (or other undertaking) in which you hold a remunerated directorship.

You must register the name of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

The situations to which the above paragraphs apply are as follows:

- you are a director of a board of an undertaking and receive remuneration – declared under category one – and
- you are a director of a parent or subsidiary undertaking but do not receive remuneration in that capacity.

Category Three: Contracts

You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in category 5 below) have made a contract with the State Hospitals Board for Scotland of which you are a member:

(i) under which goods or services are to be provided, or works are to be executed;

and

(ii) which has not been fully discharged.

You must register a description of the contract, including its duration, but excluding the consideration.

Category Four: Houses, Land and Buildings

You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the State Hospitals Board for Scotland.

The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making. If in doubt, you may consult with the Standards Commission.

Category Five: Shares and Securities

You have a registerable interest where you have an interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of the State Hospitals Board for Scotland. You are not required to register the value of such interests.

The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in shares and securities could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making. If in doubt, you may consult with the Standards Commission.

Category Six: Non–Financial Interests

You may also have a registerable interest if you have non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the State Hospitals Board for Scotland. It is important that relevant interests such as membership or holding office in other public bodies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described.

The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any non-financial interest could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making. If in doubt, you may consult with the Standards Commission.

5 Declaration of Interests

Introduction

The key principles of the Code, especially those in relation to integrity, honesty and openness, are given further practical effect by the requirement for you to declare certain interests in proceedings of the State Hospitals Board for Scotland. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions.

Public bodies inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in the State Hospitals Board for Scotland and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.

In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must keep in mind that the test is whether a member of the public, acting reasonably, might think that a particular interest could influence you.

If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be

perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration and you are advised to err on the side of caution. You may also seek advice from the Standards Commission.

At the time Board Members' interests are declared, they should be recorded in the Board minutes. The minutes containing information about the interests of Board Members should be drawn to the attention of the Board's internal and external auditors. Any changes should also be declared within 4 weeks of the change occurring and recorded in the Board minutes.

Any remuneration, compensation or allowances payable to a Chairperson or other non-executive Member by virtue of paragraph 4 of Part I, or paragraph 13 of Part II, of Schedule I of the National Health Service (Scotland) Act of 1978 or any amendment thereof, shall not be treated as a pecuniary interest for the purpose of these Standing Orders.

Interests which Require Declaration

Interests which require to be declared may be financial or non-financial. They may or may not be interests which are registerable under this Code. Most of the interests to be declared will be your personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration.

Shares and Securities

Any financial interest which is registerable must be declared. You may have to declare interests in shares and securities, over and above those registerable under category five of section 4 of this Code. You may, for example, in the course of employment or self-employment, be engaged in providing professional advice to a person whose interests are a component of a matter to be dealt with by a Board.

You have a declarable interest where an interest becomes of direct relevance to a matter before the body on which you serve and you have shares comprised in the share capital of a company or other body and the nominal value of the shares is:

(i) greater than 1% of the issued share capital of the company or other body; or

(ii) greater than £25,000.

You are required to declare the name of the company only, not the size or nature of the holding.

Houses, Land and Buildings

Any interest in houses, land and buildings which is registerable under category four of section 4 of this Code must be declared, as well as any similar interests which arise as a result of specific discussions or operations of the State Hospitals Board for Scotland.

Non-Financial Interests

If you have a registered non-financial interest under category six of section 4 of this Code you have recognised that it is significant. There is therefore a very strong presumption that this interest will be declared where there is any link between a matter which requires your attention as a member of the State Hospitals Board for Scotland and the registered interest. Non-financial interests include membership or holding office in other public bodies, clubs, societies, trade unions and organisations including voluntary organisations. They become declarable if and when members of the public might reasonably think they could influence your actions, speeches or votes in the decisions of the State Hospitals Board for Scotland.

You may serve on other bodies as a result of express nomination or appointment by the State Hospitals Board for Scotland or otherwise by virtue of being a member of the State Hospitals Board for Scotland. You must always remember the public interest points towards transparency particularly where there is a possible divergence of interest between different public authorities.

You will also have other private and personal interests and may serve, or be associated with, bodies, societies and organisations as a result of your private and personal interests and not because of your role as a member of the State Hospitals Board for Scotland. In the context of any particular matter you will have to decide whether to declare a non-financial interest. You should declare an interest unless you believe that, in the particular circumstances, the interest is irrelevant or without significance. In reaching a view you should consider whether the interest (whether taking the form of association or the holding of office) would be seen by a member of the public acting reasonably in a different light because it is the interest of a person who is a member as opposed to the interest of an ordinary member of the public.

Interests of Other Persons

The Code requires only your interests to be registered. You may, however, have to consider whether you should declare an interest in regard to the financial interests of your spouse or cohabitee which are known to you. You may have to give similar consideration to any known non-financial interest of a spouse or cohabitee. You have to ask yourself whether a member of the public acting reasonably would regard these interests as effectively the same as your interests in the sense of potential effect on your responsibilities as a member of the State Hospitals Board for Scotland.

The interests known to you, both financial and non-financial, of relatives and close friends may have to be declared. This Code does not attempt the task of defining “relative” or “friend”. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of the State Hospitals Board for Scotland.

Making a Declaration

You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether agendas for meetings raise any issue of declaration of interest. Your declaration of interest must be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed you must declare the interest as soon as you realise it is necessary.

The oral statement of declaration of interest should identify the item or items of business to which it relates. The statement should begin with the words "I declare an interest". The statement must be sufficiently informative to enable those at the meeting to understand the nature of your interest but need not give a detailed description of the interest.

A "Declaration of Interests Form" is required to be completed on an annual basis.

Effect of Declaration

Declaring a financial interest has the effect of prohibiting any participation in discussion and voting. A declaration of a non-financial interest involves a further exercise of judgement on your part. You must consider the relationship between the interests which have been declared and the particular matter to be considered and relevant individual circumstances surrounding the particular matter.

In the final analysis the conclusive test is whether, in the particular circumstances of the item of business, and knowing all the relevant facts, a member of the public acting reasonably would consider that you might be influenced by the interest in your role as a member of the State Hospitals Board for Scotland and that it would therefore be wrong to take part in any discussion or decision-making. If you, in conscience, believe that your continued presence would not fall foul of this objective test, then declaring an interest will not preclude your involvement in discussion or voting. If you are not confident about the application of this objective yardstick, you must play no part in discussion and must leave the meeting room until discussion of the particular item is concluded.

Dispensations

In very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and non-financial interests which would otherwise prohibit you from taking part and voting on matters coming before your public body and its committees. Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

6 Lobbying and Access to Members of Public Bodies

In order for the State Hospitals Board for Scotland to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which the State Hospitals Board for Scotland conducts its business.

You will need to be able to consider evidence and arguments advanced by a wide range of organisations and individuals in order to perform your duties effectively. Some of these organisations and individuals will make their views known directly to individual members. The rules in this Code set out how you should conduct yourself in your contacts with those who would seek to influence you. They are designed to encourage proper interaction between members of public bodies, those they represent and interest groups.

Rules and Guidance

You must not, in relation to contact with any person or organisation who lobbies, do anything which contravenes this Code of Conduct or any other relevant rule of the State Hospitals Board for Scotland or any statutory provision.

You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon the State Hospitals Board for Scotland.

The public must be assured that no person or organisation will gain better access to, or treatment by, you as a result of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a fee basis on behalf of clients be given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of the State Hospitals Board for Scotland.

Before taking any action as a result of being lobbied, you should seek to satisfy yourself about the identity of the person or organisation who is lobbying and the motive for lobbying. You may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that you know the basis on which you are being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code.

You should not accept any paid work

(a) which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation.

(b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence the State Hospitals Board for Scotland and its members. This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the State Hospitals Board for Scotland, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of the State Hospitals Board for Scotland.

The Members Model Code should be read in conjunction with Standing Financial Instructions of the State Hospitals Board for Scotland.

7 Training and Development of Members

The Chairperson of the Board is responsible for ensuring that all executive and non-executive Members make a full contribution to the Board's affairs and must, in consequence, determine the training and development needs of Members and ensure that any gaps in knowledge or experience are resolved.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 16
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Governance/Board Secretary
Title of Report:	Blueprint for Good Governance- Board Improvement Plan
Purpose of Report:	For Decision

1. SITUATION

The NHSScotland Blueprint for Good Governance outlines a model for effective corporate governance, to deliver good governance in healthcare. Version 2 of the plan was issued through Scottish Government in December 2022.

2. BACKGROUND

The Blueprint describes the functions and enablers of good governance, as well as definitions of the delivery systems and evaluation mechanisms required for continuous improvement. Through this NHS Boards should take a consistent and systematic approach to assessing their governance arrangements with a view to identifying any emerging issues or concerns.

A key part of this is a Board self-assessment survey, which focuses on how effective NHS Boards are against the Blueprint model in relation to the functions, enablers, delivery approaches and evaluation. All NHS Boards use the same set of questions to self-assess against the Blueprint, and a questionnaire was issued by the Scottish Government in October 2023. Within the State Hospital (TSH) all Board Members and other Executive Directors, as well as Senior Managers who regularly attend Board meetings were invited to take part on the survey. In total 16 questionnaires were issued, and all were completed.

3. ASSESSMENT

A Board Development session as arranged on 7 March 2024, inviting all of those who completed the questionnaire to attend. The session was led by the Board Development Team from NHS Education for Scotland, who provided a summary of the outcomes of the self-assessment and facilitated detailed discussion, to help identify areas of existing good practice as well as areas for improvement. This session infirmed the development of the draft Board Improvement Plan (Appendix A).

The plan has been prepared adopting the headings and format required by Scottish Government, and using the excel spreadsheet that all Boards have been issued with.

The key themes emerging from the session included recognition of areas of strength for the Board especially around setting the direction and leadership of strategic plans, and monitoring performance and scrutiny of evidence. The session supported reflection on the progress the Board has made in respect of managing risk and awareness of risk appetite. This will be developed further as part of the improvement plan, especially relating to increased financial challenges and linking the Corporate Risk Register to the Corporate Objectives.

In terms of stakeholder engagement, the plan includes development of a stakeholder map to help give clarity in this area, defining stakeholders, and how TSH engages in different forums. There is also a stated aim to raise awareness of the whistleblowing standards, and support staff to raise concerns.

The plan sets out the intention to develop further bench-marking tools and opportunities; as well as better promoting the work of TSH through collaboration with National Boards.

The self-assessment had also highlighted the positive working relationships between colleagues across the governance system, and the demonstration of NHSScotland values and behaviours throughout. There is a recognition of the need to support the enablers function through structured succession planning.

The Corporate Management Team (CMT) considered the draft plan at their meeting on 3 April 2024.

For governance of progress against the plan, it is proposed that this is reviewed by the Board in six months, to consider progress made. An annual review should then take place by the Board in April 2025.

4. RECOMMENDATION

The Board is asked to approve the Board Improvement Plan, so that it can be submitted to Scottish Government by 26 April 2024 as required. The Board is also asked to agree the governance arrangements around monitoring of the plan going forward as set out in this paper.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	To embed continuous improvement of governance arrangements as part of the Blueprint of Good Governance
Workforce Implications	No issues identified in terms of staff resourcing
Financial Implications	There are no direct financial impacts related to progressing this plan
Route to Board Which groups were involved in contributing to the paper and recommendations.	As per national guidance, and the Board has ownership directly. The CMT reviewed this as per of their agenda prior to the plan coming to the Board.
Risk Assessment (Outline any significant risks and associated mitigation)	This is a continuous improvement mechanism, and should not present additional risks to the Board.
Assessment of Impact on Stakeholder Experience	Stakeholder engagement is a key part of the plan, and will be reviewed as part of the proposed governance arrangements
Equality Impact Assessment	This is not required as part of this workstream
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	This is not relevant to this workstream
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Appendix A

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Status	intended good governance outcome
Functions	Risk Management	Review the Board risk appetite in light of current financial and operational pressures. Ensure that this is agreed and the risk management approach is embedded across the organisation, including through the development of local risk registers, and linking Corporate Risk Register to Corporate Objectives.	Standing committees	Director of Security, Resilience and Estates	Feb-25	Underway with regular updates to Board and Standing Committees. To continue to develop across each directorate locally, and bring together in CRR.	Intent is to link risk, performance and governance in more streamlined way for clarity and for continual assurance reporting going forward.
Functions	Engaging Stakeholders	Produce a stakeholder map to define who our stakeholders and the purpose of our engagement. Review our Anchor strategy as a mechanism to develop community engagement and help with visibility and impact.	External agrencies e.g. MWC, patients and carer groups, government, elected representatives and wider public	Director of Nursng and Operations/Head of Planning, Performance & Quality/OD	Feb-25	This is new workstream - stakeholder map leads to be agreed then developed, building on exisitng workstreams. Anchor Plan agreed and baseline metrics in place.	To define TSH stakeholders more clearly and the links to each, and to develop targetted engagement alongside planning espacially in relation to change programs.
Functions	Influencing culture	Raise awareness of Whistleblowing Champion to improve levels of psychological safety and support staff to raise concerns.	INWO, Scottish Government	Director of Workforce (to be reviewed?)	Aug-24	TSH to reposnd to INWO advice in respect of executive leadership of whistleblowing i.e. not an HR function. Need for Exec lead to work with HRD to develop planning for staff suport	To support staff to understand how to raise concerns through business as usual mechanisms and policies, and also how to raise cocerns through wihsitleblowing. To impact culture so that this is seen positive way of speaking up through range of mechanisms
Enablers	Diversity, Skills, and Experience	Include succession planning through Staff Governance Committee	Link to communications planning, and public perceptions	Director of Workforce	May-24	Build on work initiate in Workforce Governance Group - add to next SGC agenda as starting point, and to scope issues and key risks. Strategy and action	Nees to bring reporting to SGC to help define key areas of risk, and give assurance on action plan to mitigate the future risks and help develop staff locally to support retention.
Delivery	The Assurance Framework	Explore further benchmarking opportunities and tools, keeping the Board updated.	NHS England High Secure , Forensic Netwrok,	All Directors through CMT	Oct-24	Covers range of areas and underway across directorates- single lead to be agreed for more coherence : e.g. attendance management, digital inclusion, security , complaints, HR policy implementation etc	To stregthen assurance on range of metrics in more meaningful way, and in the right context given the Board's sepcialist role. To gelp gain learning and seek improvement across range of metrics.
Evaluation	Evaluation	Better promote our work to national Boards through raising our profile, host visitors and bespoke work. Opportunity to observe Board meetings in other areas to see how they function and identify any areas of learning.	National Boards Collaborative forums e.g. CEO, DoFs, Planning Leads	All Directors through CMT	Nov-24	Covers range of areas - single lead to be agreed to give more structured and coherence : e.g. finance, procurement, SLAs , healthcare in custory, forensic network , infirmaton governance , PMVA techniques	To promote and share sepcialised expertise within the Baord, as well as ways of seeking learning and new ways of working

Paper No : 24/31

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 17
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning. Performance and Quality
Title of Report:	TSH Annual Delivery Plan 2024/25
Purpose of Report:	For Noting

1 SITUATION

Scottish Government produced guidance for NHS Boards to develop Annual Delivery Plans (ADP) for 2024-25. The guidance requested detailed actions for 2024/25 which are aligned to both their three year financial plans and the ministerial priorities, including recovery drivers. The ADP outlines what TSH will deliver across the year. It is expected to be affordable within the context of the Board's financial plan and Boards should ensure that the workforce is in place to support service delivery. The ADP was submitted as requested, by 7 March 2024. A formal letter has yet to be received from Scottish Government (SG) accepting the plan, however feedback has been positive so far from SG regarding the content of the ADP

2 BACKGROUND

The Annual Delivery Plan (ADP) forms part of the governance and sponsorship arrangements with Scottish Government. Quarterly reports on progress will be submitted to Scottish Government to update and discuss delivery and emerging priorities and issues.

In 2023-24, the Scottish Government also commissioned NHS Boards to develop medium term plans (MTP) to outline delivery over 3 years. The State Hospital did not provide a medium term plan in 2023/24, in agreement with Scottish Government Health Planning and the Mental Health Policy Team due to ongoing uncertainty about the longer term governance and strategic leadership structure of forensic mental health system. TSH will develop a medium term plan over 2024/25.

3 ASSESSMENT

The ADP 2024-25 was developed following planning sessions with Directors and Directorate Teams. Over 40 staff were engaged in the development sessions in January/ Feb 2024. The sessions focused on key ambitions for 2024/25, the financial challenges and possible solutions for this. The structure of the plan follows the template that SG requested Boards to adopt, the TSH plan has the following areas:

- Recovery Drivers – aligned to finance plan
    - Improve the delivery of mental health support and services
    - Health inequalities
    - Implementing the workforce strategy
    - Digital service innovation adoption
    - Climate emergency and environment
    - Patient care – physical health, patient pathways, realistic medicine
    - Security
- Service Sustainability
- Risks and Issues – associated with delivery, financial balance and workforce and mitigations for identified risks.

Table 1 below provides an overview of the key projects included in the ADP.

Table 1 - ADP - Key priorities & projects for 24/25 delivery

FINANCIAL CONTROL AND GOVERNANCE			
Workforce	Clinical	TSH priorities	Strategic development
Reduce absence and manage this proactively	Embed clinical model	Digital inclusion	Clarity on independent Review in Forensic Services
Implement Health and Care Staffing bill – support e-rostering embedding	Implement the Clinical Care Policy	Develop security audit programme	Strategic Leadership Board
Staff wellbeing	Improve meaningful activity for patients – no DTC	Resilience and business continuity models	Develop medium term plan
OD strategy	Supporting Healthy Choices	Compliance with internal and external assurance audits and implementation of audit actions (NIS etc)	Climate and environment emergency – funding for net zero targets
Directorate and dept. restructures and develop workforce to deliver	QI and Realistic Medicine	Develop planned and preventative facilities maintenance programme	Capitol programme to be prioritised with tightening budgets
Workforce strategy – review and develop next 3 year strategy	Physical Health of patients	Development of business intelligence dashboards and financial process in management accounts	Anchors strategy
Occ Health SLA – review of year 1	Overtime and SSR	Clinical Quality and Research Strategies to be developed	Forensic system collaborations
Workforce- 36 hour week	Out boarding and resource management	Procurement and tenders for SLA' s	Improvements in custody healthcare
SERVICE SUSTAINABILITY			
RISKS AND ISSUES ASSOCIATED WITH DELIVERY AND FINANCIAL BALANCE			

4 RECOMMENDATION

Board members are invited to note and discuss this report.

The ADP 2024/25 will be published, once formal approval has been received from Scottish Government.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	The Annual Delivery Plan sets out the key delivery priorities for TSH over the period.
Workforce Implications	Not assessed formally – the plan outlies the key strategic responsibilities for TSH in terms of workforce
Financial Implications	Not assessed formally – the plan outlies the key financial responsibilities for TSH
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	Direct to the Board
Risk Assessment (Outline any significant risks and associated mitigation)	Not formally assessed
Assessment of Impact on Stakeholder Experience	The plan sets out the key deliverables for TSH and will be monitored by SG
Equality Impact Assessment	An EQIA is not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One □x There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 18
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Communications
Title of Report:	Communications Service Update
Purpose of Report:	For Noting

1. SITUATION

The Board is seeking an update on Communications. This update is provided as at 12 April 2024 and covers the redevelopment of the Intranet, our business case for rebranding, and staffing / resources.

2. INTRANET REDEVELOPMENT

2.1 Background

The current Sharepoint Intranet site (now at end of life) is managed by eHealth. eHealth and Communications are working collaboratively to implement a new Intranet site, Sharepoint Online (SPO). When implemented, this will be adopted by Communications with corporate responsibility transferring from eHealth to Communications.

SPO is being led nationally for all Boards by National Services Scotland (NSS). The project is still at an early stage nationally pending resources, governance approvals and other necessary requirements to ensure successful implementation across NHSScotland.

Implementation of SPO ensures compatibility with all other M365 software, services, and applications. It allows the introduction of various M365 products that we are currently unable to implement fully without having M365 SharePoint Online, including OneDrive, sensitivity labelling, Business Classification Scheme, Security & Compliance features. It ensures we are utilising the latest software, which is robust, secure, and supported.

A new SharePoint solution would provide staff with a modern interface, with easy navigation, search and collaboration tools, ensure content is accurate, relevant, and up-to-date.

SPO can also be accessed on any device e.g. mobile phones and tablets, without the need to be onsite or connected to the Hospital network through remote access, providing greater accessibility for staff.

2.2 Assessment

Since the last Board update, good progress has been made to help ensure local readiness for when we get the green light nationally to proceed. Of particular note:

- Intranet Upgrade Action Plan – This has been developed and continues to be reviewed and updated. It identifies content and Content Contributors.

- Content Contributors Engagement – Meetings commenced with this group of stakeholders to discuss their requirements in terms of content, whilst also ensuring that the comments from the stakeholder exercise were taken on board. This aspect of the project is ongoing as content will change with time. We do not plan to do a whole site content migration from the existing site to SPO.

- SPO Training - Members of the SPO Project Team enrolled on national SPO training sessions.

Next steps (short-term)

- Meet legislative requirements – full Data Protection Impact Assessment (DPIA) to be developed.
- Participate in training opportunities – eHealth and Communications to continue to take advantage of free online Sharepoint training made available via Microsoft to aid familiarisation.

Next steps (longer-term)

The intention is still to work with someone external to build the new SharePoint site - someone with the experience and knowledge of M365 SharePoint. However, this is dependent on what the national programme can offer. It is certainly still an option if we think we need it and can find the money to pay for it.

From there, the State Hospital can create and maintain content. This will involve training for identified staff including Communications, eHealth, Learning Centre and Content Contributors.

Timescale

Work continues nationally around governance and support. Until this is complete, the advice nationally is that Sharepoint online is not to be implemented. Implementation could be some time off – 12 months possibly. Meantime, the current Intranet site continues to be live and content updated.

3. BRANDING

3.1 Background

The Scottish Government is reviewing the NHSScotland national branding. This provided an opportunity for the State Hospital to put a business case forward for a State Hospital variant of the NHSScotland logo that more clearly identifies the State Hospital as an NHSScotland organisation. Branding includes both logo and name. All NHS organisations within the family use NHS in their name and so any change is likely to mean that our name would change to NHS State Hospital and NHS State Hospitals Board for Scotland as appropriate.

A business case was submitted in January 2023. In December 2023 this was updated at Scottish Government request and resubmitted.

3.2 Assessment

The process is taking much longer than anticipated although supported by both the Scottish Government Communications team and our Sponsorship Team. The Sponsorship Team will put this before the Cabinet Secretary as and when appropriate. We continue to be patient and chase up at every opportunity.

4. STAFFING

4.1 Background

In 2022, the Board approved the appointment of two Communications posts:

- PR & Media Communications Officer - Specific emphasis being placed on raising the profile of the State Hospital by engaging and educating stakeholders through the daily management of social media channels and the creation of content.
- PR & Digital Communications Officer – Key areas of responsibility include the Website and Intranet.

The PR & Media Communications Officer moved onto pastures new in November 2023 having been in post for a year. In December 2023, the post was re-advertised, and interviews were undertaken, but no appointment was made.

4.2 Assessment

Proposed service development, as approved by the Board in 2022, is dependent on a full complement of three posts.

Due to the current financial climate there is now a need to be more cautious about spend and an increased requirement to make savings. A Communications Assistant post is being explored in place of the higher banded PR & Media Communications Officer post. This would achieve the necessary savings for 2024/25 and future years, and would also meet service requirements.

If the Communications Service was to move forward with only two posts, then a review of proposed enhancements and changes to service delivery may need to be paused, e.g. provision of a video production service in line with other NHS Boards and best practice, and the handover of the Intranet from eHealth to Communications.

5. RECOMMENDATION

The Board is asked to note the update.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	In support of the Board's Communications Strategy and strive to raise the profile of the State Hospital so it can be more clearly identified.
Workforce Implications	Increased workload for Communications.
Financial Implications	Proposed developments aim to reduce financial burden, e.g. replace PR & Media Communications Officer with a lower banded Communications Assistant post.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Corporate Management Team.
Risk Assessment (Outline any significant risks and associated mitigation)	The upgrade of the Intranet diminishes the risk associated with the existing version, SharePoint 2007, which is out of support and is no longer fit for purpose. Additionally, the current Intranet also does not integrate with other M365 applications such as Teams and OneDrive, and the security and compliance components of the M365 Programme. Capacity to deliver on proposed new developments and handover of the Intranet from eHealth to Communications is questionable with only a complement of two staff.
Assessment of Impact on Stakeholder Experience	Positive impact on all stakeholders.
Equality Impact Assessment	An EQIA is in place for the Communications Strategy.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No issues identified.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ☐ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☑ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 19
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Programme Director
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
Purpose of Report:	For Noting

1. SITUATION

This report to the Board summarises the current status of the Perimeter Security and Enhanced Internal Security Systems project. Board members are asked to note the overall project update, the financial report and any current issues under consideration by the Project Oversight Board.

2. BACKGROUND

From a governance and oversight perspective, the following schedule of control and interface points between TSH and Securitas UK are in place:

- Twice weekly *(Mon & Thursday)*: Site operational meeting
- Weekly Technical Review Meeting
- Weekly: 'Look ahead' meeting
- Twice monthly: Strategic Oversight Group
- Monthly: Project Oversight Board

The Project Oversight Board meeting last took place on 18th April 2024; The next Project Oversight Board is scheduled for 16th May 2024. The meeting of 18th April discussed the requirement for Post Project Review and agreed that the key elements of the Post Project Review should be the requirements of the August 2018 Gateway Review and the Full Business Case Service Benefits Evaluation Plan. The Project Oversight Board agreed that this should be confirmed by The State Hospitals Board.

3. ASSESSMENT

a) General Project Update:

The project is in the final stages. All quality targets are being met; project completion remains scheduled for July 2024 (see Project Timescales for a detailed overview of current progress at 3b below) and costs are projected to overspend (See Finance – Project Cost at point 3c below).

b) Project Timescales

Programme revision 56 has been rejected and revision 57 is in development. A verbal update on Revision 57 will be available to the Board.

The installation of technology is substantially complete and currently forecast for completion in May. Remaining works will then be final elements of installation, Site Acceptance Testing of the installation and production of documentation. Some CCTV issues still require resolving, though progress has been made; difficulties in addressing these issues have been the primary cause of programme delay.

c) Finance – Project cost

The project is proceeding according to the current projected cost plan, in that the contract with Securitas is due to underspend against budget, including available contingencies. Project management costs and associated contingencies have been affected by changes in the project timescale. The project currently has a potential overspend (exclusive of VAT) of approximately £646k. This has decreased by approximately £7k since the February report to the Board.

The key project outline at the end of March 2024 is:

Project Start Date:	April 2020
Planned Completion Date:	July 2024
Contract Completion Date:	May 2022
Main Contractor:	Securitas Technology Limited
Lead Advisor:	Thomson Gray
Programme Director:	Doug Irwin

Total Project Cost Projection (Exc. VAT) at 31/03/24:	£9,438,326
Total costs to date (exc. VAT & retention) at 31/03/24:	£9,251,192
Total costs to end of project (Exc. VAT & retention)	£ 187,134

The cash flow schedule planned for the months to come is confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our SG funding drawdown is scheduled accordingly. All project payments are processed only once certification is received confirming completion of works to date.

While it is not a prerequisite of the project, regular reports to the SG Capital team are also being provided to notify of progress against total budget. A letter to Scottish Government was issued week commencing 29 January 2024 as part of the financial planning for 2024 – 2025 outlining the projected spend from April 2024 to anticipated end date and this has been accepted.

A Rounded breakdown of actual spend to date (Exc. VAT) at the end of March 2024 is:

Securitas	£ 7.269m
Thomson Gray	£ 1.049m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 0.834m
Income	-£ 1.001m
Total	**£ 9.251m**

VAT has been excluded from calculations of amounts paid due to the need for the reclaim to be applied for and assessed.

4 RECOMMENDATION

That the Board **note** the current status of the Project and **approve** the proposed elements of the Post Project Review.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Update paper on previously approved project
Workforce Implications	N/A
Financial Implications	***The projected overspend is regularly communicated to Scottish Government and is an ongoing action at Project Oversight Board.***
Route to the Board Which groups were involved in contributing to the paper and recommendations?	Project Oversight Board
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	***Contract agreement stipulates compliance with Fairer Duty in respect of the remuneration of staff and contractors.***
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ϒ There are privacy implications, but full DPIA not needed ϒ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND **ARC(M) 23/03**

AUDIT AND RISK COMMITTEE

Minutes of the meeting of the Audit Committee held on Thursday 25 January 2024.

This meeting was conducted virtually by way of MS Teams, and commenced at 09.30am.

Chair:	
Non-Executive Director	David McConnell
Present:	
Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Pam Radage
In Attendance:	
External Auditor, KPMG	John Blewett
External Audit Director, KPMG	Michael Wilkie
Chief Executive	Gary Jenkins [From Item 9 onwards]
Board Chair	Brian Moore
Director of Finance and eHealth	Robin McNaught
Director of Security, Estates, and Resilience	David Walker
Head of Risk and Resilience	Allan Hardy
Head of Estates and Facilities	Kenny Andress [Item 10]
Head of Procurement	Stuart Paterson [Item 14]
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Secretary & Head of Corporate Governance	Margaret Smith
Personal Assistant	Julie Burt [Minutes]

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting, and he advised that there were no apologies submitted for today's meeting.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 28 September 2023 were noted to be an accurate record of the meeting.

The Committee:

1. Approved the minutes of the meeting held on 28 September 2023.

4 MATTERS ARISING – ACTION PLAN UPDATE

There were no additional urgent matters which arose for discussion.

The Committee received the action list and noted progress on the action points from the last meeting.

Members were content to note all actions as complete and closed, with the exception of number one.

The Committee:

1. Noted the updated action list.

INTERNAL AUDIT

5 INTERNAL AUDIT PROGRESS REPORT

Ms Vicky Gould of RSMUK provided an overview of the Key Financial Controls Report dated 25 January 2024. Members noted that the internal Audit Plan for 2023/24 was previously approved by the Audit & Risk Committee (ARC) at its meeting in March 2023. The report provided an update on progress against that plan and summarised the results of the work to date. Ms Gould advised that one final report had been issued since the last meeting i.e. Patient Monies, which would be discussed in detail under item 6 on the agenda. She advised that positively, the organisation remained on track to deliver the internal Audit Plan in line with the timetable. Considering the changes previously reported, good progress had been made in implementing previous internal audit actions, which were detailed on the action tracking report. Lastly, she advised that RSMUK were in the process of liaising with Executive colleagues to develop the 2024/25 Internal Audit Plan, which would be presented to the ARC meeting before the year end.

Mr Walker commented on the target timescale noted within the report in relation to the Security Review, i.e. April 2024. He advised this had moved to a more likely completion date of June 2024. Ms Gould noted this information and recommended that further discussion take place under the Risk Register item where Members could review any potential risks raised from this delay. Mr McConnell reminded the Committee that this was part of the ongoing planning review.

The Committee:

1. Noted the Internal Audit progress Report dated 25 January 2024.

6 INTERNAL AUDIT REPORTS – PATIENT MONIES REPORT

Members received and noted the Internal Audit Report on Patient Monies dated 15 January 2024. Ms Gould provided an overview of, and advised of the background to, the report. She advised that this report was added to the Audit Plan as part of the three year strategy. In terms of the report conclusion, she advised that the State Hospital had a suitably designed internal control structure in place to manage and safeguard patient funds, however some areas for improvement were identified. These included improvement around the control structure, including but not limited to, following established procedures for cash withdrawals and emergency ward cash requests. She advised that four management actions were raised (one 'medium' and three 'low priority) to address this as detailed within the report.

Ms Gould further advised that taking account of the issues identified, the Committee took reasonable assurance that the controls upon which the organisation relied to manage this risk were suitably designed, consistently applied and effective. However, the identified issues required to be addressed in order to ensure that the control framework was effective in managing the identified risks.

Mr McNaught thanked RSMUK for their report and welcomed the audit given that it was last reported on three years ago. He noted the overall positive report and that action points raised were fair and would be taken on board.

Ms Radage acknowledge the positive report and commented on the larger sums of money some patients had within the Patients Bank. She queried whether there would become a time when the

hospital would provide advice on what to do with such specific high sums of money, for example, providing guidance on interest rates. Mr McNaught advised that the Finance Department were unable to offer patients any financial advice given that they were not qualified in that regard, though could offer to provide contact details of financial advisors.

Mr Moore made reference to the Trojan system referred to in the recommendation section and queried if there was scope for improvement or to streamline this system in any way to refine the process as a whole. Mr McNaught advised that other system options were reviewed and would be taken forward as part of the Digital Inclusion Plan, however, given budget pressures the plan would be reviewed to establish what areas of improvement the hospital would and would not be able to take forward. He advised that the Patients Bank element was hopefully an area to progress where funding could be accommodated, though would need to be reviewed within the overall budget plan.

The Chair acknowledged the useful and helpful report and discussion and thanked RSMUK for the report.

The Committee:

1. Noted the Internal Audit Patient Monies Report dated 15 January 2024.

7 INTERNAL AUDIT TRACKING REPORT

Members received and noted the Internal Audit Management Actions Tracking Report dated 17 January 2024 which provided the Committee with comments on progress made in respect of previous internal audit findings and agreed management actions. Ms Gould provided a brief overview of the report and advised that an analysis of all actions with new revised target dates was included. She further advised that, of the 12 actions live on the tracker, eight were not yet due, however one of these had already been implemented i.e. sustainability. The remaining four actions had all been implemented and these related to the Performance Management and Incident Management audits. Updates were received from all action owners, and information on progress of those actions not yet due. She advised that RSMUK would work with management between now and the year end to understand whether any of the sustainability actions that were due for implementation by 31 March 2024 would require to be extended, and if so, this would be reported on at the next meeting.

Mr Walker advised that there may be slippage in achieving set targets in relation to difficult decisions that would require to be taken around funding. He advised that the Head of Procurement and the Head of Estates and Facilities would meet to review the actions noted within the paper, and it was hoped good progress would be made between now and the end of March 2024.

Ms Gould noted this useful information in terms of awareness of any slippage of target dates for actions and advised that the actions themselves would be updated as and when required. She also thanked actions owners for their robust updates to date.

The Committee:

1. Noted and approved the changes to the Internal Audit Management Actions Tracking Report dated 17 January 2024.

EXTERNAL AUDIT

8 EXTERNAL AUDIT PLANNING / PROGRESS REPORT 2022/23

Mr Blewett of KPMG presented the indicative External Audit Plan for the year ended 31 March 2024 and advised that the full Audit Plan including the wider scope elements would be shared with Members at the March Committee meeting.

He advised that KPMG determined materiality for the Board financial statements at a level which could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements. He explained that a benchmark of expenditure was used which was considered appropriate as it reflected the scale of the Board's services.

He provided an overview of the early reflections on audit risks such as the expenditure recognition completeness, valuation of land and buildings, and management override of controls. All three were noted to be significant risks.

He further advised that in addition, estimates would be discussed which had not changed and the valuation of land and buildings and provisions value, had not changed in terms of their nature from last year, with KPMG not aware of any new claims or litigations for example. Lastly, the audit cycle was noted and it was reiterated that the full audit plan would be presented at the March 2024 meeting, with a focus on field work in May and June. Audit Scotland had made it clear that their expectation of audit providers was for the process to be completed in June 2024.

Mr McConnell wished to confirm that the late iteration would be the extra part which would be included in the full report. Mr Blewett advised this was the case and that work was underway on the four wider scope areas.

Members thanked Mr Blewett for the helpful update and advised they looked forward to receiving the audit plan at the next committee meeting. Should the final plan be available prior to the meeting, this would be shared with Members in advance. Secretariat noted to ensure this was added to the March 2024 agenda.

Action: Secretariat

The Committee:

1. Noted the indicative External Audit Plan for the year ended 31 March 2024.

INTERNAL CONTROL AND CORPORATE GOVERNANCE

9 CORPORATE RISK REGISTER UPDATE

The Committee received and noted the Corporate Risk Register update which was presented by Mr Walker, who advised there were no out of date risks and proceeded to provide an overview and update on each corporate risk.

Mr Walker highlighted that ND71 i.e. Serious Injury or Death as a Result of Violence and Aggression (previously ND71 - Failure to assess and manage the risk of aggression and violence effectively), had been updated to better reflect the risk of violence and aggression within The State Hospital. He explained that all current control measures and Datix data were considered with the risk assessment now focusing on serious injury from violence and aggression incidents, a change from the previous focus of all violent incidents. The assessment highlighted that the majority of incidents were managed without issue or injury, and therefore the risk to staff and other patients would reflect this. After analysing the data, the risk was reduced from High to Medium and would be monitored regularly by the Health and Safety Committee, Clinical Governance Group and Clinical Governance Committee.

In terms of high and very high risks, this was reduced to two i.e. MD30 Failure to prevent / mitigate obesity, and ND70: Failure to utilise resources to optimise excellent patient care and experience. Again, these would both be monitored by the Clinical Governance Group and Clinical Governance Committee.

Mr Walker gave a brief overview of the proposed risk for inclusion on the Corporate Risk Register i.e. HRD113 Job Evaluation, and advised that Human Resources Department developed a Risk Assessment relating to the impact of delays within the job evaluation process and the potential impact this may have on services. The Risk Assessment detailed the control measures in place to

minimise the impact of this process as well as that ongoing work that is underway to mitigate the risk further. The risk was approved by the Corporate Management Team and was currently graded at Moderate to Possible giving the overall rating of Medium.

Mr Currie commented that the majority of risks noted made reference to finance and resourcing issues and queried if the inability to fund activities or to make appropriate savings, and draw back to a specific level, was a risk itself. He further questioned what risks this would present to operational activities, should these not be able to be delivered. Mr Jenkins joined the meeting at this point and advised that in terms of the overall financial risk to the organisation, it would be helpful to determine within the Risk Register, where finance would be a challenging factor. He further advised that a Planning Workshop Day with the Director group was held on 15 January 2024 where it was agreed to attempt to contextualise the Annual Delivery Plan in the frame of what actions would be taken in the present financial landscape. Mr Jenkins highlighted that the three year Finance Plan was due for submission on 29 January 2024 and thereafter the hospital would be able to be explicit and determine the level of impact on services at that point.

In relation to ND71 Mr Moore commented that he was unsure of the clear distinction between 'serious injury from violence' and 'violence incidents' and questioned if any significant changes were expected as a result of this redesign of definition. Mr Hardy advised that as a high secure forensic hospital it was recognised that violence was an expected factor though it is how we recognise the difference between serious violence towards our staff and the low level of violence expected due to the nature of our patient cohort. This overall piece of work would be routed to Local Risk Registers to be managed and maintained locally on agendas, though from a corporate and organisational piece of work, this would be routed to the higher level of serious risk of violence towards staff. We would like to reduce the risk in such a way that we can see significant events, and work on these to put controls measures in place to mitigate the risks.

Mr Moore asked if the hospital captured the psychological factors of serious events given that there may be cases where the results of an incident may have a longer impact on staff than the act of violence itself. Mr Hardy advised that robust supporting mechanisms were in place for staff including through the Occupational Health Service. He further advised that debriefs were held following such an event to capture any learning points required.

The Chair thanked Mr Walker and his team for the overall, positive report. Members reviewed and noted the Corporate Risk Register as an accurate statement of risk and approved the addition of HRD113 and the update to ND71 to the register.

The Committee:

1. Reviewed and agreed the Corporate Risk Register as an accurate statement of risk, and

2. Approved the addition of HRD113 and the update to ND71 to the Corporate Risk Register as detailed above.

3. Agreed no additional information was required for future reports given the usefulness of its current form.

10 CLIMATE EMERGENCY AND SUSTAINABILITY

(a) Annual Report 2022/23

Members received and noted the Annual Climate Emergency and Sustainability Report 2022/23. Mr Andress joined the meeting at this point and provided an overview of the content for the benefit of the Committee.

Mr Andress explained that Health Boards were required to report on an annual basis against the aims of DL (2021) 38 i.e. a Policy for NHS Scotland on the Climate Emergency and Sustainable Development, and that this was the second year the report would be completed and returned to the Scottish Government, following approval by the Board. He advised that the purpose of the report

was to focus on the environmental performance of the organisation, which allowed the hospital to reflect on its performance against the standards and allows any outstanding actions or forward planning to be highlighted.

Mr Andress advised that in summary, the State Hospital had already reduced emissions by 81% against the 1990 baseline year. Therefore the State Hospital was well-ahead of the 2030 target. However, without targeted decarbonisation measures, the State Hospital would not meet the other two key targets of decarbonised heat by 2038 and Net Zero by 2040. The bulk of carbon savings in 2030 were proposed to be delivered by deployment of on-site renewable generation, whereas in 2040 it was the decarbonisation of heat that would drive the health board towards Net Zero. Other areas to highlight were in procurement, where sustainability formed a core part of any regulated tenders or quick quotes. The implementation of the Anchors Strategic Plan showed the commitment of the State Hospital to be an anchor institution for the local community.

An independent audit regarding Environmental, Social and Governance Review was carried by external auditors RSM. This audit identified, that given the resource and financial restrictions faced in terms of sustainable development, that the hospital was in a position to fulfil the requirements by 2040.

Lastly, he advised that focus for this year would be to develop and implement a high-level waste route map, to move forward with an active travel agenda, increase biodiversity/greenspace awareness, and create a plan to achieve Net Zero by 2040 in line with the overarching Net Zero Route Map that was produced by Jacobs for The State Hospital.

Mr Walker thanked Mr Andress and Mr Hardy for preparing the report and advised that there were areas where the hospital required to prioritise areas within the net zero route map in terms of funding and resources. He advised that the unique and rural location of the State Hospital did not lend itself to a simple implementation of wind turbines, or generating solar energy or ground source heat pumps, therefore challenges were recognised. He also acknowledged the foreseen challenge on site of capital investment given that the hospital was already fifteen years old and there was a need to ensure the buildings remained fit for purpose.

Mr Currie highlighted the future increased expectation of electric vehicle usage, and that the hospital would therefore have to ensure there was available infrastructure for this as staff habits change and more electric vehicles were purchased. Mr Andress advised that as part of the active Travel Agenda, the hospital were looking at how to better provide for staff in terms of driving to work or other available options. Regarding the charging points, he advised that the infrastructure to cover all State Hospital vehicles has been installed and that the hospital was up to date in this area. He advised that the hospital has 14 charging points in the car park which is full electrical capacity for the site. We are unable to add to our infrastructure even if we had external grants and money. It would be up to Scottish Power to increase our infrastructure, however other potential available options would be reviewed in future.

The Chair thanked Mr Andress and Mr Walker for the very informative and helpful report. He acknowledged that The State Hospital was a unique site.

Mr Jenkins commented that there may be some difficult decisions required to be made in terms of budgetary focus going forward. In relation to transport, he suggested and supported additional discussion around alternative ways to travel to and from the hospital which Mr Andress previously made reference to.

Mr McConnell acknowledged that the reporting timeframe of the Annual Report was for the period 2022 – 2023 and queried its route to the Board in terms of corporate governance and given that the Audit and Risk Committee was a governance Committee.

Ms Smith advised that due to timescales, the report was due for submission to the Scottish Government by 31 January 2024 and the report had not been fully completed in time for the Board meeting in December 2023. She therefore suggested discussion took place at today's meeting with a decision made by the Committee, where the report would then be circulated to the Board members if this was helpful. From a Board point of view, Mr Moore agreed this would be helpful to

circulate to all Board Members and acknowledged that Ms Cathy Fallon, Non-Executive Director and as Sustainability Champion, was already familiar with the content of the report.

Action: Ms Margaret Smith

The Committee:

1. Approved the content of the Annual Climate Emergency and Sustainability Report for 2022/23 for submission to Scottish Government, on the proviso that it was circulated to Board Members prior to its submission.

(b) Sustainability Management Group Update

Members received and noted the update on progress made by the Sustainability Management Group and the NHS The State Hospital Net Zero Routemap Report. Mr Walker provided an overview of the report and made reference to the background Mr Andress alluded to in item 10a, specifically DL (2021) 38 'A Policy for NHS Scotland on the Climate Emergency and Sustainable development', which was issued in November 2021 and set out aims and associated targets for NHS boards to work towards. There were a total of 68 separate actions that were required to take forward. RSMUK carried out the audit as mentioned earlier in the meeting, whereby 'reasonable assurance' was provided in terms of the hospitals compliance with DL (2021) 38. Mr Walker advised that the Risk Assessment remained at medium though as the funding position became clearer that may change in terms of achieving net zero by 2040, however this would be kept under review by the Sustainability Management Group. Progress update, planned work and the reporting schedules were also noted.

The Committee:

1. Noted the Sustainability Management Group update and the NHS The State Hospital Net Zero Routemap Report

11 FINANCIAL REPORT

Members received and noted the Financial Report on the position as at 31 December 2023. Mr McNaught advised this was the first report of its kind presented to the Committee and would be a routine item on the agenda going forward. He advised that the report provided information on the financial performance, which was also issued monthly to Scottish Government (SG) along with the statutory financial reporting template.

Mr McNaught reported that the organisation remained on track with a breakeven forecast for the year, including meeting targets on savings and capital spend. He emphasized the awareness of expected pressures which would be faced in 2024/25 and there was a vast amount of work carried out to date towards that. The first draft template of the budget would be issued to SG next week and meetings would be held at Senior Level with the Chief Executive Officer to discuss in detail the directorate budgets for next year to ensure a clear understanding of where key pressures lie and where increased levels of savings may be able to come from. Lastly, Mr McNaught advised that he would welcome the input of the Committee on the content and format of the report and suggested that a more high level report focused on key risks and mitigating against these may be helpful.

The Chair opened up discussion on thoughts around the content of the report, with perhaps a more slightly abbreviated format, and the level of information shared with Committee within future reports.

Mr Currie acknowledged the benefit of receiving a high level detail report and would welcome this in future.

In terms of content of the report and which information was received going forward, Ms Radage raised that condensed reports remove duplication and allow for better conversation within

Committee meetings, therefore would be supportive of a more condensed report with signposting around the key points.

Mr Moore commented that detail should be presented at this Committee, with a more brief report given to other meetings, given that finance would be a major theme across the coming year, therefore full exposure across all governance bodies was important. He further commented on the reference to more Consultant time was being recharged for external work; post base budget setting, giving rise to a considerable favourable variance within the medics update and queried if this was new posts or fulfilling existing vacancies given reference to the budget pressure. Mr McNaught explained this was recharges to other NHS Boards and some notifications came through at a late stage which resulted in some recharges to other Boards attempted to claw back some time from earlier periods, therefore this brought additional income which was not expected in the current period. This then offset new appointments as costs were increased. Lastly, he confirmed these were covering existing vacancies.

Ms Radage made reference to, section 3.4 and sought clarification on vacancies within nursing. Mr McNaught explained there was an element of vacancy levels where overtime costs incurred, which would be less if those posts were filled, and that this was being reviewed. Ms Radage noted that the year to date budget versus the year to date actual was very similar. Mr McNaught advised this was the whole time equivalent rather than the whole number of staff who were in post.

Mr Jenkins highlighted that the narrative within the report required to be refined and agreed to take this forward with Mr McNaught outwith the meeting, and perhaps at the Board Development session on 1 February 2024.

Action: Mr Robin McNaught / Mr Gary Jenkins

Members agreed that the Committee would benefit from a more nuanced report going forward and noted that discussion would take place around this topic of discussion at the Board Development Session on 1 February 2024. The Committee noted the position and forecast of revenue and capital year to date positions.

The Committee:

1. Noted the Financial Report on the position as at 31 December 2023.

2. Agreed that a reformatted nuanced report would be discussed and presented at future Committee meetings.

12 FRAUD UPDATE AND ACTION PLAN

The Committee received and noted the Fraud report which provided an update on fraud allegations and notifications received from Counter Fraud Services (CFS).

Mr McNaught provided an overview of the report and advised there were no matters of concern that were required to be brought to the attention of the Committee for the purposes of review. He advised that CFS virtual sessions continued to be circulated. Members noted the four new alerts circulated by CFS in the last quarter and noted the two updates on fraud allegations within the hospital.

The Committee:

1. Noted the Fraud update for the period of the last quarter.

Members received and noted the Fraud Action Plan which included an update on the Board's approach to countering fraud. Mr McNaught provided an overview of the report in terms of the activities used to gauge CFS level of engagement with each Board and that these activities would be the basis of discussion during their annual customer engagement visit.

As Fraud Champion, Mr Currie advised he had attended various Fraud meetings who were attended by staff who have an operational job role as well as Non-Executive Directors. He gave a brief overview of helpful discussions at these meetings and what they entailed in terms of raising the profile around Fraud and particularly Fraud Prevention.

Mr Moore referred to the two allegations in 2023/24 which came from CFS and advised it would be helpful to understand the category of these allegations and how they might, or might not, relate to the hospital's fraud risks. Mr McNaught advised that this related to attendance and no incidences of fraud were found. He provided some background of the closed allegation to which Members were content to note. Members agreed that the Committee would benefit from a generalised category heading to be added in the reports would be beneficial to allow a broad understanding and nature of what the issues were with regards to fraud allegations. Mr McNaught agreed to ensure broad headings were added in to future reports.

Action: Mr Robin McNaught

Mr Moore also made reference to the new Fraud Strategy within the Action Plan which was circulated to Non-Executive Directors, where this resulted in a request to hold a briefing on this topic. Ms Smith advised that the plan was to request attendance of CFS to attend a Board Development Session in the near future. She explained this was in hand and would be planned through the next scheduled sessions in 2024.

Action: Ms Margaret Smith

The committee noted the progress on engagement activities as well as the update on Communication. Members reviewed the Fraud Action Plan Statement from CFS and noted no further revision to the Top Ten Risks identified from the FRAM i.e. appendix.

The Committee:

1. Noted the Fraud Action Plan.

13 CYBER CRIME REPORT

Members received and noted the Cyber Security and Awareness Activities update which was presented by Mr McNaught. In summary, he advised that there had been no impact on the Board from any national or local specific security risks which had been raised in the last quarter. The hospital continued to be notified of any risks that were in the general national impacts and also have strong awareness of any current risks that are known, which are circulated to staff as and when they arise. He advised that the hospitals systems continued to be successful in detecting and quarantining any possible cyber threats, and that staff awareness, training and education continued to play a significant part of our digital defence.

The Committee:

1. Noted the Cyber Security Crime Report.

14 PROCUREMENT ANNUAL REPORT 2022/23

The Committee received and noted the Procurement Annual Report which highlighted the activity within the Procurement Team to ensure transparency and openness in all of its contracting activity during the period April 2022 to March 2023. Mr Stuart Paterson joined the meeting at this time and provided a brief overview of key points within the report.

Mr Currie wished to have it confirmed that the majority of the spend was in relation to revenue rather than capital spend given that it was not improving an asset to maintain something. He also commented areas of work where the hospital spend could be made within the community to try and encourage working with local businesses, though he acknowledged that striving for best value may

mean that the local businesses lose out given that there may be more savings to be made with other national companies and contracts. He queried if discussions took place prior to decisions been made. Mr Paterson confirmed that there was attention to detail in such cases and given the new Anchor Strategy, the hospital did report on local business spend. He advised that in dialogue with key stakeholders, for example Head of Estates and Facilities, options around placing orders locally was a routine topic of discussion. He also advised that the organisation was fortunate given that the majority of spend was under £50k, which meant the hospital were able to select companies themselves to bid for contracts. Spend above £50k was open tender and regulated. Mr Paterson advised he asked at National Procurement Groups to raise this level amount to try give more business to local companies. The outcome of this query was awaited, however would be reflected in the 2023/34 report.

Mr Moore referred to working with colleagues in other National Boards on collaborative initiatives, and queried if we expected anything to come from this over the next twelve month period. Mr Paterson advised this could be challenging but the State Hospital did utilise, for example, a NES contract for car leasing.

Mr Moore also referenced the arrangements the hospital had with territorial Boards and the number of Service Level Agreements and that it might be useful to provide additional detail in terms of what these were. Mr Paterson explained this was possible however these were not included in the report as it was not part of the information requested by Scottish Government. He added that this could be added to future reports for the benefit of the Committee, i.e. which SLA's were being worked on.

Action: Mr Stuart Paterson

Mr Jenkins highlighted that it was an interesting approach, given that the State Hospital was a National Board, they had these opportunities with the other National Boards. Mr Jenkins added that it would be helpful to review what opportunities existed within National Boards to collaborate in this way. He also highlighted the work involved in the Anchor Strategy and that this would perhaps give the organisation better latitude around value for money on lower spend items.

The Chair thanked Mr Paterson for his helpful report. He noted this report covered the period 2022/23 and acknowledged that the 2023/24 Annual Report would be presented at the September 2024 meeting and was noted within the Committee Workplan.

The Committee:

1. Noted the Procurement Annual Report 2022/23.

15 LEGAL CLAIMS ANNUAL REPORT 2022/23

The Committee received and noted the Legal Claims Annual Report 2022/23 which summarised the claims activity for the financial year, against comparative data for the previous two years. Ms Smith provided a brief overview of the report and advised it was recognised there was a need for reporting to the Audit and Risk Committee on the legal claims position and related spend. It was acknowledged that this report covered the period 2022/23 and that the Annual Report for 2023/24 would be presented at the September 2024 Committee meeting and would include past liability spend. Secretariat agreed to add this to the Workplan.

Action: Secretariat

She advised that the hospital receive a low numbers of claims given its size, in comparison to other Boards, and provided background to CNORIS. In terms of outstanding claims, she acknowledged that it was challenging to report on what the outstanding risks were, and the present position without breaching confidentiality. She explained due to the small number of claims and the nature of these, to split them into employers liability or clinical negligence for example, to provide a risk rating, was not possible given the small number received.

Ms Radage questioned if the claims noted were generated from the employee, external to the hospital, or if there simply was not any sense on this given the small number of claims. Ms Smith highlighted the range of areas which would be managed through the scheme and reiterated the number was too low to confirm this. In terms of any actions which were required to be taken forward following settled claims, the hospital generated learning from this which was taken forward if required. Mr Jenkins offered the option of allowing discussion with Non-Executive members at the Private Session of the Board should they wish to receive additional and in depth claims information and discuss this.

The Committee:

1. Noted Legal Claims Annual Report 2022/23.

INTERNAL UPDATES FOR INFORMATION

16 SECURITY, RISK AND RESILIENCE, HEALTH AND SAFETY GROUP UPDATE

Members received and noted the Security, Risk and Resilience, Health and Safety oversight group update, which Mr Walker provided an overview. No issues or concerns were raised.

The Committee:

1. Noted the Security, Risk and Resilience, Health and Safety oversight group update.

17 FINANCE, EHEALTH AND AUDIT GROUP UPDATE

Members received and noted the Finance, eHealth and Audit Group update as was presented by Mr McNaught. Members noted the report content and recognised no areas of escalation were required.

The Committee:

1. Noted the Finance, eHealth and Audit Group update.

18 ANY RELEVANT ISSUES ARISING TO BE SHARED WITH GOVERNANCE COMMITTIEES

1. As agreed under item 11 above, further discussion would take place around the Financial Report at the Board Development Session on 1 February 2024.

2. As agreed under item 10a above, the Annual Climate Emergency and Sustainability Report 2022/23 would be circulated to Non-Executive Board members prior to 31 January 2023.

19 ANY OTHER BUSINESS

There was no other business.

20 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Thursday 21 March 2024 at 9.30am via MS Teams.
End of meeting 1200 hours.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2024
Agenda Reference:	Item No: 20
Title of Report:	Audit and Risk Committee – Highlight Report
Purpose of Report:	For Noting

This report provides the Board with an update on the key points arising from the Audit and Risk Committee meeting that took place on 21 March 2024.

1	Internal Audit	The Committee received progress reporting on audit activity for the current year, and it was noted that there were no further audit assignments available. The clinical model audit was in progress, and the security review audit had been necessarily deferred and substituted by an audit of the quality improvement programme taken forward within complaints management. The audit plan for 2024/25 was reviewed and agreed. Internal auditors presented an updated tracking report, which evidenced good progress on audit actions from management. The Committee also received briefings on the following: Global Internal Audit Standards, Emerging Risks Radar, and Taking Action to Manage Risks and Drive Improvement
2	External Audit	The External Auditors confirmed good progress on the work to complete the 2023/24 audit, including an Indicative External Audit Plan. Work was on track to complete this within the required timescales.
3	Corporate Risk Register	The Committee received a report on the position on the Corporate Risk Register, highlighting recent updates including the position on risks rated as high and risk distribution. There were no new risks to be considered. It was highlighted that the risk maintaining a sustainable long term financial model had been graded as high.
4	Serious Adverse Events – Update	The Committee received an update on progress made with outstanding actions from Serious Adverse Event Reviews, as well as an update as to how these were managed with the Corporate Management Team taking oversight to ensure progress and learning.
4	Finance	The Committee received an update on the financial position noting that the expectation remained for breakeven for 2023/24. It was confirmed that the draft plan for 2024/25 was being finalised for submission to Scottish Government, encompassing the required savings to be made.
5	Counter Fraud	The Committee received a quarterly summary of alerts received from Counter Fraud Services (CFS). There had been three national

		alerts, and these had been communicated to staff. There was an update on the Fraud log, and that the CFS Lead would attend the Board Development Session in May.
6	Cyber Crime Report	The Committee noted confirmation that no specific high risks had arisen for the organisation, with systems continuing to be successful in identifying and quarantining possible cyber threats.
7	Anchors Strategy	The Committee noted update on the need to develop clear baseline data in relation to workforce, local procurement and use and disposal of land and assets for the benefit of the community. This was to be submitted to Scottish Government by 29 March 2024, and was on track. This will be used to measure future progress.
7	Security Audit – Update	The Committee noted an update on the annual audit of the perimeter and physical security measures. The methodology for this was being reviewed led by the CMT, benchmarking for best practice, and further reporting would be brought back to the Committee.
8	Policy Update	The Committee received assurance reporting on the management of policy reviews, led through the Policy Approval Group and progress being made in this area. Slight upturn noted in the number of policies requiring review and need for continued focus to improve position.
9	Draft Governance Statement	The Committee received and noted a draft of the Governance Statement, which will form part of the Accountability Report (Corporate Governance Report) section of the Annual Report and Accounts.
10	Review of Standing Documentation and Accounting Policies	The Committee reviewed standing documentation, including Standing Financial Instructions, Scheme of Delegation and Standing Orders recommending their adoption by the Board. The Committee also reviewed the Members Code of Conduct.
11	Annual Review of Committee Terms of Reference	The Committee undertook a review of its own terms of reference with no suggested amendments.
12	Reports from Governance Groups	The Committee received and noted update reports on their recent work from the Security, Resilience and Health and Safety Group, and from the Finance, eHealth and Audit Group.

RECOMMENDATION

The Board is asked to note this update, and that the full meeting minute will be presented, once approved by the Committee

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	As part of corporate governance arrangements, to ensure committee business is reported timeously to the Board.
Workforce Implications	None through reporting – information update
Financial Implications	None through reporting – information update
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested, pending approval of formal minutes
Risk Assessment (Outline any significant risks and associated mitigation)	Committee update only as part of governance process – no specific risks to be considered unless raised by committee chair/members for Board attention.
Assessment of Impact on Stakeholder Experience	No assessment required as part of reporting
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included