**THE STATE HOSPITALS BOARD FOR SCOTLAND**
**BOARD MEETING**

**THURSDAY 24 APRIL 2025**
**at 9.30am**
**Hybrid Meeting: in Boardroom and on MS Teams**

**A G E N D A**

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| **9.30am** | | | |
| **1.** | **Apologies** | | |
| **2.** | **Conflict(s) of Interest(s)**<br>To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed. | | |
| **3.** | **Minutes**<br>To submit for approval and signature the Minutes of the Board meeting held on 27 February 2025 | For Approval | TSH(M)25/01 |
| **4.** | **Matters Arising:**<br>**Rolling Actions List: Updates** | For Noting | Paper No. 25/21 |
| **5.** | **Chair's Report** | For Noting | Verbal |
| **6.** | **Chief Executive Officer's Report** | For Noting | Verbal |
| **7.** | **Volunteer Story: "Volunteer Experience within The State Hospital"**<br>**Introduced by the Director of Nursing and Operations** | For Noting | Presentation |
| **8.** | **High Secure Forensic Healthcare Services for Women**<br>Report by the Chief Executive Officer | For Noting | Paper No. 25/22 |
| **10.15am** | **RISK AND RESILIENCE** | | |
| **9.** | **Corporate Risk Register**<br>Report by the Acting Director of Security, Estates & Resilience | For Decision | Paper No. 25/23 |
| **10.** | **Finance Report – to 31 March 2025**<br>Report by the Director of Finance & eHealth | For Noting | Paper No. 25/24 |
| **11.** | **Bed Capacity Report:**<br>**The State Hospital and Forensic Network**<br>Report by the Medical Director | For Noting | Paper No. 25/25 |
| **10.40am** | **CLINICAL GOVERNANCE** | | |
| **12.** | **Nursing Resource Strategy 2025/26**<br>Report by the Director of Nursing and Operations | For Noting | Paper No. 25/26 |
| **13.** | **Quality Assurance and Quality Improvement**<br>Report by the Head of Planning, Performance and Quality | For Noting | Paper No. 25/27 |

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| **14.** | **TSH Carers Travel Scheme**<br>Report by the Acting Director of Security, Resilience and Estates | For Decision | Paper No. 25/28 |
| **11.am** | **BREAK** | | |
| **11.10am** | **STAFF GOVERNANCE** | | |
| **15.** | **Health and Care Staffing Annual Report**<br>Report by the Director of Nursing and Operations | For Decision | Paper No. 25/29 |
| **16.** | **Staff Governance Report**<br>Report by the Director of Workforce | For Noting | Paper No. 25/30 |
| **17.** | **Whistleblowing Annual Report**<br>Report by the Director of Workforce | For Noting | Paper No. 25/31 |
| **18.** | **Protecting Vulnerable Groups: Update**<br>Report by the Director of Workforce | For Noting | Paper No. 25/32 |
| **11.40am** | **CORPORATE GOVERNANCE** | | |
| **19.** | **Health Board Collaboration and Leadership**<br>Report by the Chief Executive | For Decision | Paper No. 25/33 |
| **20.** | **Annual Review of Standing Documentation:** | For Decision | |
| | **(a) Standing Financial Instructions and Scheme of Delegation** | | Paper No. 25/34 |
| | **(b) Standing Orders and Members Code of Conduct** | | Paper No. 25/35 |
| | Report(s) by the Director of Finance and eHealth Head of Corporate Governance | | |
| **21.** | **Board Improvement Plan**<br>Report by the Head of Corporate Governance | For Noting | Paper No. 25/36 |
| **22.** | **Communications Annual Report 2024/25**<br>Report by the Head of Communications | For Noting | Paper No. 25/37 |
| **23.** | **Network and Information (NIS) Update**<br>Report by the Director of Finance & eHealth | For Noting | Paper No. 25/38 |
| **24.** | **Perimeter Security and Enhanced Internal Security Systems Project**<br>Report by the Acting Director of Security, Resilience and Estates | For Noting | Paper No. 25/39 |
| **25.** | **Audit and Risk Committee:**<br>Approved Minutes of meeting held 30 January 2025 | For Noting | ARC(M) 25/01 |
| | Report of meeting held 27 March 2025 | | Paper No. 25/40 |
| **26.** | **Any Other Business** | | Verbal |
| **27.** | **Date of next meeting:**<br>12.30pm on 19 June 2025 | | Verbal |
| **28.** | **Proposal to move into Private Session, to be agreed** | For Approval | Verbal |

**in accordance with Standing Orders.**
Chair

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| **29.** | **Close of Session** | Verbal |

**Estimated end at 12.30pm**

**THE STATE HOSPITALS BOARD FOR SCOTLAND** **TSH (M) 25/01**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 27 February 2025.

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

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| **Chair:** | Brian Moore |

**Present:**

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

**In attendance:**

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| Acting Director of Security, Estates & Resilience | Allan Hardy |
| Head of Communications | Caroline McCarron |
| Social Work Mental Health Manager | David Hamilton |
| Head of Planning, Performance and Quality | Monica Merson |
| Head of Corporate Governance/Board Secretary | Margaret Smith [Minutes] |
| Director of Workforce | Stephen Wallace |

## 1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone and noted that there were no apologies for the meeting.

He also acknowledged that a member of the public had joined the meeting by way of teams, to observe the 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 19 December 2024 were noted to be an accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 19 December 2024.

## 4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted that actions had progressed or were on the agenda for today's meeting. The progress on Excellence in Care Walkrounds was noted, especially the positive links made with other NHS Boards.

The Board:

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

Mr Moore noted that consideration of a dedicated space being made available to the Patients' Advocacy Service within the Skye Centre had been discussed at the meeting and asked about progress. It was agreed that an update would come back to the Board in this respect. It was also agreed that the Board would receive an update on engagement with the Patients Partnership Group on the role of the Board, and of Non-Executives within that.

**Action(S) – Mr Jenkins/ Ms Smith**

## 5 CHAIR'S REPORT

Mr Moore opened his update by saying how pleased he had been to attend the Staff Excellence Awards, which had taken place at the hospital on 26 February. It had been a positive celebration of staff and had been very well organised. Mr Moore offered the Board's thanks to the Organisational Development Team who had supported the event. It had been an enjoyable afternoon, with good attendance from staff as well by Board Members.

Ms Radage had also been at the event, and she echoed Mr Moore's remarks, adding that she felt it had been a great way of acknowledging the good work that staff had taken forward throughout the year. Mr Jenkins also thought it had been an excellent day, and he reflected on the importance of staff engagement more widely noting that the Corporate Management Team (CMT) had endorsed a 'TSH3030' event in May this year, and that an update would come to the Board's next meeting.

**Action – M Merson**

Mr Moore advised that he had attended two sessions of the NHS Board Chairs Group. He summarised the key themes of meeting which included national, regional, and local collaboration, as well as digital transformation and NHS Reform. The group had received a presentation from NHS Lanarkshire on the Flow Navigation Centre and had also considered the challenging financial landscape across NHSScotland, considered the review of business systems e.g. payroll services, and the population health ten-year plan due for publication later this year.

He commented that it would be useful for NHS Reform to be part of the next Board Development Session, to help understand the parameters of this, the national landscape, and the potential impacts for the State Hospital (TSH).

**Action – M Smith**

The Board:

1. Noted this update from the Chair.
2. Agreed to review NHS Reform within Board Development Session.

## 6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins advised in January, both Mr McNaught and Mr Wallace had attended a national event held at Murrayfield Stadium around the Business Services Programme in public services, and possible gains that could be made.

He had attended a summit session on 17 February led by Mr Ivan McKee (Miniter for Public Finance) in respect of financial efficiencies for NHS Scotland. Further, that a meeting would take place between NHS Board Chief Executives and the First Minister Mr John Swinney on 2 March.

He commented on the Board Development Session that had taken place on 23 January and had included a range of topics including Realistic Medicine, Equalities Outcomes, and key planning workstreams: Annual Delivery Plan, Medium Term Plan, Financial and Workforce Planning.

He also noted the impact of Storm Eowyn, which had impacted the power supply to the hospital with there being a requirement for a shift to generator power, and wider resilience planning.

He advised that CMT had reviewed and endorsed reporting on management of unscheduled care for TSH patients, involving cross system working with NHS Lanarkshire. This work was ongoing, and further reporting would be routed through the Clinical Governance Committee.

**Action – L Thomson/ M Smith**

He confirmed that a mock cyber security exercise had taken place within TSH on 25 February through the resilience framework, and that the lessons on this would return to CMT with assurance being provided to the Board thereafter.

He noted that an extension to the Service Level Agreement for the provision of Occupational Health Services through NHS Dumfries and Galloway had been agreed by CMT and reviewed and endorsed by the Staff Governance Committee.

Mr Jenkins said that the Medical Director of Health Improvement Scotland (HIS) had recently visited the hospital, meeting with himself and Professor Thomson and touring the site. This had been a productive visit and included the focus on the HIS Inspection programme. He noted that the Forensic Governance Advisory Group had also had a tour of the hospital site and would be meeting with the Board later this afternoon.

He brought Board awareness to the commencement of National Insurance charges for employers on 1 April 2025, which would in part require to be met by NHS Boards.

He advised that TSH had an engagement session with NHSScotland Chief Operating Officer, Mr John Burns, on 10 February, which had been constructive.

Within TSH, CMT had endorsed a digital pilot within the Transitions Service, and the results of this would return to the Board.

He also advised that the Board Chief Executives (BCE) Group would be holding a session on mental health on 12 March, hosted by the Director of Mental Health Mr Stephen Gallacher along with Mr Jenkins.

Next week, there would be an event to celebrate patients' achievements which would be hosted by Mr Moore. Carers and families were also going to come along to the event. Lastly, Mr Jenkins noted that a development day would take place on 28 February, for the Clinical Model Oversight Group to reflect on the management structure after the first 18 months of the new clinical model.

Mr McConnell asked about the NHSScotland Reform Agenda, saying that he agreed that it would be helpful to have a focused session within a Board Development Session. He highlighted the need

to look at the barriers to reform, and how TSH could engage with this workstream. Mr Currie picked up on this point, saying that it was likely that there would be impacts for TSH both directly and indirectly. It would be interesting to see how this progressed both for territorial and national NHS Boards. In terms if timescale, he indicated that there was a need for the pace to be considerable, moving forward within weeks rather than months. Further the pace of reform would need to continue beyond the short term phase leading up to the electoral period in May 2026. The focus should be on effecting long terms change.

Mr Jenkins said that there was a clear duty to collaborate where possible, while at the same time acknowledging the areas in which this would be more challenging. He noted the need to look at synergies across forums in NHSScotland, and links to the wider public sector.

The Board:

1. Noted the update from the Chief Executive.
2. Agreed that NSH Reform Agenda should be scheduled for 1 May 2025.

## 7 HIGH SECURE FORENSIC HEALTHCARE SERVICE FOR WOMEN

The Board received a paper (Paper No. 25/02) from the Chief Executive Officer, on the initial stages of the High Secure Forensic Healthcare Services for Women.

Mr Jenkins summarised the content of the paper, noting the parameters of the proposal to develop an interim women's service model to receive pre-trial and pre-sentence patients, assessed to need high secure care; as well as an outreach service model to high secure and medium secure providers and the Scottish Prison Service. This was Phase 1 and had a go live date of July 2025. In the medium to longer term, the Phase 2 proposal was for the creation of a dedicated care and treatment centre for women.

Mr Jenkins outlined the background relating to the funding which had been confirmed to establish a project team and take forward planning. This had been set up with work under way to develop the interim service within Mull 3 ward. He noted the governance framework through which oversight would be taken on the project with the establishment of a Project Oversight Board which was chaired by Mr Currie and would report directly to the Board. Mr Jenkins also highlighted the importance of the Equality Impact Assessments developed for each phase of the project and the need to obtain legal advice through the Central legal Office to ensure compliance with Human Rights and Equality legislation.

Mr Moore thanked Mr Jenkins for this update and opened to questions. Ms Fallon asked about whether the project would have a dedicated Risk Register, or if this project would be added directly to the Corporate Risk Register. Mr Jenkins confirmed that a stand-alone risk register was being created for the project and that this would be reported through the Project Oversight Board. However, it should also be included within the overall Corporate Risk Register. Mr McConnell agreed with this point and went on to ask if it was realistic for the interim service to open in July of this year given the short timescale. Mr Jenkins said that the expectation was for Mull 3 ward to have been modified including outdoor space, and for CCTV to have been fitted. There would be an Admissions Protocol, and staffing would be in place. Therefore, by July 2025, TSH would be in a position to admit pre-sentence female patients, who had been assessed as requiring high secure care.

Ms Radage asked about how regularly the TSH Board would receive updates from the Project Oversight Board given the meeting schedule. Mr Currie agreed that the TSH Board should receive more regular updates especially as there may be dynamic issues that the TSH Board should have awareness of. He advised that this would be part of the set up of the Project Oversight Board. Presently, he had direct contact with Mr David Walker, Programme Director on a weekly basis. There was agreement around the table for the TSH Board to receive more regular monthly updates, as well as the regular updates to the formal Board Meetings.

**Action – Mr Walker**

In answer to a further question on the bed capacity of the interim service, Mr Jenkins confirmed that it was for three to four patients within one ward. This would be dependent on the Admissions Protocol and would be clinically led. Professor Thomson agreed and pointed to this relating to pre-sentence patients only, not on the return of any patients from Rampton Hospital in NHS England.

Mr Jenkins also noted the potential impact on contingency planning of opening Mull 3 ward, confirming that he had highlighted this to the Mental Health Directorate.

Mr Moore summarised for the Board by saying that this was a very fast paced development, and that Mr Jenkins had set out the expectations clearly. Mr Currie would take the lead on governance, and reporting would come through directly to the TSH Board.

The Board:

1. Noted this update.

## 8 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 25/03) from the Acting Director of Security, Resilience and Estates to provide an update on the Corporate Risk Register.

Mr Hardy summarised reporting, noting that there had been some positive movement with streamlining of the register with four risks being removed. These had either been merged with other risks or had been remitted to the relevant local risk register. There were four risks which remained graded as high, and 13 risks were at their target level and 11 were not. Mr Hardy explained that as part of the work to analyse risk appetite, additional longitudinal data had been added to the report. This helped to demonstrate whether risk remained static, or where there had been movement.

Ms Fallon agreed that the longitudinal grids were useful as a one-off presentation to take stock of the position. She also asked about Risk SD 57 – Adverse Event review and Action Completion, which had increased to high in October 2024 and continued to be at this level. Mr Hardy acknowledged the pressures within the team, as well as an increase in the number of reviews which had been required to be carried out over a short space of time. Mr Moore refenced the national perspective and the increased scrutiny through HIS inspections – he thought that there was a need for consistency and improvement in this area. Mr Jenkins advised that he had met with the Risk Manager to review the Serious Adverse Events Reviews (SAERs) which were outstanding and the reasons for this. This was a particular challenge within a small organisation, should the numbers of reviews increase. He provided assurance that the CMT do actively review any outstanding actions to ensure that any indicated actions were taken forward as necessary pending the final report.

There was agreement that SAERs should be added to the Board Development Meeting Schedule.

**Action – Ms Smith/ Mr Hardy**

Ms Radage referred to Risk MD30 – Failure to prevent/ mitigate obesity and the ongoing work across the wider workstream on patient health, which should help to bring improvement.

Mr Moore summed up the discussion, saying that the pro-active approach to risk was welcome, and that this reporting was beneficial for the Board. The recommendations of the report were accepted by agreement around the table.

The Board:

1. The Board reviewed the current Corporate Risk Register and approved it as an accurate statement of risk,
2. Added SAERs framework and reporting to Board Development Schedule.

## 9 FINANCE REPORT TO 31 JANUARY 2025

The Board received a paper (Paper No. 24/04) from the Finance and eHealth Director, reporting on the financial position to 31 January 2025 (Month 10).

Mr McNaught provided an overview, noting that there was a small adverse variance at this date of £0.147m, which was mainly driven by ward nursing pressures. He advised that it was still anticipated that a year-end break-even position would be achieved.

Regular reporting continued to Scottish Government, and further that meetings were being held on a monthly basis with each directorate to address savings plans. He also noted continued monitoring of capital spending, including the small additional amount made available within the current year.

Mr McConnell asked about the capital charges for depreciation of buildings which had been backdated, and Mr McNaught confirmed that this related to the Perimeter Security Project, and the timing of capitalisation as each part of the works was signed off. Mr McConnell also asked about the additional non -recurring funds of £325k under capital allocation, and Mr McNaught confirmed that this had been allocated. The final amount involved was being finalised as this was an estimated amount; and funds had been set aside by Scottish Government on this basis.

Mr Moore asked about the additional pressure of employers' National Insurance contributions in the next financial year. Mr McNaught confirmed that there was no formal agreement in this regard to date. Mr McConnell also asked if there had been any increase in requested reviews under AfC nursing banding, as this could bring financial pressures, and Mr Wallace confirmed that a small number had been received to date.

Mr Moore noted the position as outlined, with a break-even position being forecasted.

The Board:

1. Noted the content of the report.

## 10 BED CAPACITY REPORT

The Board received a paper (Paper No. 24/05) from the Medical Director, which outlined bed capacity within TSH for the period 1 December 2024 to 31 January 2025. Professor Thomson asked the Board to note this position, including the flow of patients between services within the hospital. She noted that there were 101 patients in the hospital as of today's date. Contingency planning had not been required for Major Mental Illness patient during this period.

Professor Thomson also confirmed that the Forensic Network had completed their Capacity and Patient Flow Report, and that this had been submitted to Scottish Government in December 2024. A copy of the report was appended to this report for information.

Mr Moore noted thanks to Professor Thomson and said that it was helpful to have sight of the Forensic Network report, which was also relevant in the context of the current review of governance of wider forensic mental health service being led by the Forensic Governance Advisory Group and also provided insight to the links with the Scottish Prison Service.

Mr Moore thanked Professor Thomson for this update, which helped inform the Board of the wider position.

The Board:

1. Noted the content of report.

## 11 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 24/06) which outlined quality assurance and improvement activities during the past two months.

Ms Merson summarised the content of reporting covering three clinical audits which had been completed and actioned, as well as the master audit sheet to indicate ward compliance on local audits. Referring to the Variance Analysis Tool, Ms Merson noted increased attendance at Care Programme Approach (CPA) meetings. She also asked the Board to note an area of concern that had been raised relating to the lack of a dedicated Occupational Therapist (OT) presently within the Transitions Service.

Ms Merson confirmed that TSH3030 would be launched in March and then was scheduled to take place in May 2025, and that the Quality Forum would support this initiative. In the past this project had successfully engaged staff across the hospital, as well as producing quality improvement ideas and initiatives. She would bring an update on progress to the next Board Meeting.

Lastly, she also noted that the Realistic Medicine Action Plan had been reviewed at the Clinical Governance Group this week and was due to be submitted to Scottish Government in March.

Ms Radage welcomed the return of TSH3030, and asked about the position regarding the vacancy for an OT within the Transitions Service. Ms McCaffrey advised that recruitment to this had been successful, and the expectation was that the service would return to its full function shortly.

Ms Fallon asked about the support that patients would get to be able to participate in TSH3030, and Ms Merson confirmed that this was available through the Person Centred Improvement Team (PCIT) and also that she would be attending the Patient Partnership Group to outline TSH3030 and the opportunities for patients to get involved. In the past, patients have shown great interest and become involved in teams. Ms Fallon commented that it would be helpful to get direct patient feedback about their involvement, as well as from staff. Ms Merson agreed that she would provide this wider feedback.

**Action – Ms Merson**

Ms Fallon also asked about the potential impacts on patients should their Key Worker not attend the CPA meeting. On this point, Professor Thomson advised that it was essential for there to be liaison with the Key Worker not only at the CPA but at all times. Should the Key worker not be available for the CPA, then the Associate Key Worker would provide cover.

Mr McConnell also welcomed the TSH3030 initiative and asked for clarity around the completion rate for Advance Statements. He noted that 60% was above the national position but asked if it was possible to find a direct dataset comparator for TSH in this respect. Professor Thomson said that there was not an exact comparator available, but that the nearest would be medium secure facilities. More widely, longer term mental health patients tended to be those who were elderly and living with dementia, and who would struggle to engage with this process should they not already have such a statement in place. She added that the compliance at TSH was at a good level, and that the Patients' Advocacy Service provided helpful support for patients in this regard.

The Board:

1. Noted the content of the report.

## 12 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 14 November 2024; as well as a summary report (Paper No 25/07) noting the key areas of reporting and discussion at the meeting on 13 February 2025. As Chair of the Committee, Ms Fallon highlighted the interesting presentation that the Committee had received from the Manager of the Forensic Network at the February meeting about engagement with People with Lived Experience, and that this would come back

to the Committee in terms of how TSH progressed this in the future.

The Board:

1. Noted the content of the approved minutes dated 14 November 2024.
2. Noted the update from the meeting held on 13 February 2024.

## 13 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 25/08) which provided the key points in relation to overall workforce performance to 31 January 2025.

Mr Wallace took the Board through a summary of this report and the range of metrics contained therein. He emphasised that the key challenge is the level of sickness absence, with a continued increase in this in January. He noted that this did reflect an increase in short term absences linked to seasonal cough, colds, and respiratory infections. At the same time there was a continuing need to reduce levels of long-term absence, particularly within nursing, and there was a need for sustained improvement. He also provided comparison to levels of absence within medium secure units which showed that this was a wider issue across services.

He advised that he would review reporting to include further background on the implications that the high levels of sickness absence had in terms of the resultant financial impacts.

**Action – Mr Wallace/Mr McNaught**

Mr Moore thanked Mr Wallace for reporting and remarked that whilst the Staff Governance Committee took detailed oversight in this area, high levels of sickness absence was an organisational risk, and he welcomed discussion by the full Board.

Ms Fallon Followed up on this point, noting that at a Committee level, there had been reporting about the areas in which sickness absence levels were most concerning. She asked about the Skye Centre in particular, and how this would impact of the delivery of patient activity. Mr Wallace commented that there were areas in which absence levels were at 17% to 22%, and that it could be expected that these high levels would present an operational challenge. Ms McCaffrey advised that in relation to the Skye Centre this was monitored through the Activity Oversight Group, and that it was usually possible to provide staffing cover for absences so that activity could continue to be delivered. At the same time, there would be direct impact should the absence be from within a specialist staffing group which could then be provided.

Mr Jenkins acknowledged that the worst performing area in this regard was nursing, and that service delivery would be impacted especially within specialist staffing groups. He referred to the additional investment made in additional ten nursing assistants and that detailed work was progressing to monitor the impacts of this, as well as a refreshed approach to performance management within nursing through which improvement was expected.

Mr Moore supported this point and said that it was important that the Board had understanding of the nature of the challenge within front line nursing. He also acknowledged the wider range of metrics within reporting, and the progress made more widely.

The Board:

1. Noted the content of the report.

## 14 WHISTLEBLOWING

### (a) Quarter 3 Report

The Board received a paper (Paper No. 25/09) from the Director of Workforce in relation to whistleblowing activity during Quarter 3, and Mr Wallace confirmed that there had been no cases received during this period. One case had been submitted for consideration, and this had been managed through business as usual routing as appropriate.

The Board:

1. Noted the content of reporting.

### (b) Whistleblowing Champion Annual Update

The Board received a paper (Paper No. 25/10) from the Director of Workforce in which he confirmed that that on the 6 February 2025, the Cabinet Secretary for Health and Social Care had written to all NHSScotland Non-Executive Whistleblowing Champions, asking for an update on this role at a Board level, as well as detail of any work undertaken to promote a positive and engaging culture within the organisation.

Mr Moore confirmed his view that it was important that the Board had the opportunity to provide input to the update and passed to Ms Raghavan to comment in her role as Whistleblowing Champion.

She led the Board through a summary of the draft response, underlining the work progressed to date including establishing a concrete process around managing any concerns raised, as well as the planned move of management of this workstream to the Corporate Team. She thought that it would be pivotal to re-establish the confidential contacts role, and to promote the links made with NHS Lanarkshire. She also underlined the importance of building up awareness through Speak Up Week, and to continue to embed the fresh approach being taken to organisational health through the Organisational Development Department. She said that she felt reassured this workstream had made significant progress during the past 12 months.

Ms Fallon commented positively on this and asked about whether there was a concern that staff were reluctant to speak up about any concerns they had, based on the draft response. Ms Raghavan clarified that this was more in relation to the wider reflections made within the Whistleblowing Champions Network, and that she did not have specific concerns in relation to TSH. Mr Wallace also noted that this was in response to a question raised by the Cabinet Secretary about overall concerns nationally.

Mr Currie reflected on the number of avenues available nationally which were ‘business as usual’ and that often whistleblowing could be the last resort within an organisation. He commented on the framework of routes available within NHSScotland and placed this within the context of strong partnership working. Further the importance of leadership and support through line managers and the importance of performance reviews in this regard as well. He thought that there was a cumulative build up of avenues available to staff to raise concerns and high levels of opportunity through which to do that. He asked about how that framework could be captured. He also said that whilst it was important not to be complacent on this, it may be that a lack of cases raised through whistleblowing was not necessarily negative.

Mr Wallace thought that there should be increased focus on the framework of routes available to staff to raise concerns, especially within Speak Up Week. It was positive for staff to approach both line managers and their trade unions in order to be supported. He would consider how to reflect this framework of business as usual avenues, going forward.

Mr Moore supported this point noting the emphasis on this within the Whistleblowing Standards. Ms Raghavan was in agreement and said that staff should have a good understanding of these wider mechanisms, and that education was the key to this. She noted that there was a legal protection within whistleblowing, and this was to ensure that staff could have their concerns heard if this were not being

managed through other routes. It was essential to ensure that staff felt that they would be listened to, and she would continue to collaborate closely with colleagues to do so.

Professor Thomson asked about the possibility of triangulating data across different metrics involving both staff and patients e.g. complaints and feedback, patient engagement, and legal challenges. This may help to highlight the issues raised. Mr Wallace said that this may be challenging given the focus on local resolution by line managers which would not be included in formal data.

Mr Jenkins noted the discussion at the Staff Governance Committee this month in which members had reviewed the minutes of the Partnership Forum and commented on the way in which these demonstrated the strong nature of partnership working enabling difficult and challenging areas to be discussed in a constructive way. He also commented on the work progressed to enable a more open and culture within TSH, which had experienced challenge in the past. Mr Connor agreed with this point and commented positively on the range of routes available to staff to raise concerns.

Mr Moore highlighted that the office of the Independent National Whistleblowing Officer (INWO) published the number of cases received on its website and that there is a decreasing number. He summed up the discussion which had been very positive, and it was agreed that the draft response would be amended slightly to reflect this. He asked about the position on executive leadership, and it was agreed that this would sit with Mr Wallace on behalf of workforce, as well as Ms Smith from a corporate perspective. Mr Raghavan thought that this was the best option within a small NHS Board, and there was agreement around the table.

It was agreed that Ms Raghavan would submit the letter to the Cabinet Secretary based on this discussion.

**Action – Ms Raghavan/ Ms Smith**

The Board:

1. Noted the content of reporting.
2. Provided further input to and endorsed the drat letter to the Cabinet Secretary.
3. Whistleblowing would be led and managed by Workforce and Corporate teams.

## 15 EQUALITIES OUTCOMES REPORT

The Board received a paper (Paper No. 25/11) from the Director of Workforce to present the Equalities Outcomes Report for 2025-29, demonstrating the plan to focus on specific areas for the organisation to achieve the outcomes and evidence of compliance with the legislative requirement of the Equality Act 2010.

Mr Wallace highlighted the key factors, which had been reviewed recently at the Board Development Session in January 2025, and the refreshed approach being taken to create an equal focus between patients, carers, and staff. He emphasised the need for this work to be taken forward in an open and transparent way, and also the proposed governance route of reporting directly to the Board.

Mr Moore welcomed the report particularly the way in which it covered the six priority areas. Ms Fallon echoed this, and also the clear presentation of these. There was discussion on how the Board could gain feedback on equality issues, and Mr Wallace said that this was something that the Workforce Equalities Group were actively considering. Mr Jenkins commented positively on the progress made to date in this area.

The Board endorsed the draft report for submission, and also that reporting route should be directly to the Board.

The Board:

1. Noted the content of reporting.
2. Approved the Equalities Outcomes Report 2025-29.
3. Agreed the reporting route directly to the Board.

## 16 STAFF GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 21 November 2024; as well as a summary report (Paper No 25/12) on the key areas of reporting and discussion at the meeting, which had taken place on 20 February 2025.

As Chair of the Committee, Ms Radage confirmed that the at its last meeting the Committee had endorsed the decision to extend the Service Level Agreement for Occupational Health Services through NHS Dumfries and Galloway. She highlighted the work that had been undertaken by the Workforce team in this respect, and that it was a beneficial partnership for the organisation. She advised that there had also been a detailed review of the challenges faced to maximise attendance. Lastly, she noted her appreciation for the work done to provide concise and focused reporting, which was helpful in opening up active discussion for members.

The Board:

1. Noted the content of the approved minutes 15 August 2024.
2. Noted the update from the meeting held on 21 November 2024.

## 17 CORPORATE OBJECTIVES 2025/26

The Board received a paper from the Head of Corporate Governance (Paper No. 25/13) to provide a high-level statement of the Board's strategic goals for the coming year, and to bring together the priorities for each strand of governance.

Ms Smith presented an overview of this, noting that the Board had been provided with a draft version which indicated each of the proposed changes. She highlighted these areas, within each part of the report. In particular, within 'Better Care' and 'Better Heath,' she noted the addition of an interim women's service and outreach service for women, and the planning of a medium to longer term model for women's services. There was an added emphasis on the physical health of patients, and the continued improvement of physical health opportunities.

In terms of 'Better Value,' Ms Smith noted the planned completion of the Perimeter Security Project, and the development of core security quality indicators for subsequent monitoring and oversight. Within 'Better Workforce' she highlighted the continued development and delivery of the three-year Workforce Plan, as well as the move into the delivery and monitoring of staff resourcing aligning with the Health and Care (Staffing) (Scotland) Bill (2019) with the first annual report due to be submitted in April 2024. Ms Smith also noted the refreshed approach to Organisation Development, using the organisational health approach as well as strengthening leadership roles. Further, an additional objective to reflect the increased focus on equality outcomes.

Lastly, she placed the Corporate Objectives within the overall performance framework of the organisation, at local and national levels.

Mr Moore thanked Ms smith for reporting, saying that the report set out the key priorities of the Board in a clear way. Mr Moore added that it would be helpful to capture the NHS Reform agenda more explicitly within the planning objectives. Mr Currie agreed with this and commented on the way this demonstrated the linkage to Scottish Government and to the national landscape. He thought that this provided good assurance, and that the governance routes of the objectives could be traced through the standing committees, as well as providing a good representation of the work being progressed within the

organisation. He thought it would be helpful to track these objectives against risk registers.

Ms Fallon agreed that reporting was clear and made some additional suggestions to consider the addition of realistic medicine as a specific objective, as well as being more specific around digital inclusion for patients. She also agreed on the inclusion of organisational development and culture as being a key priority. She raised whether it would be possible for each corporate objective to have a reference indicator, to enable report authors to demonstrate which objective their report linked to.

These additions were discussed and agreed around the table, and that a revised version would be circulated on this basis.

**Action – Ms Smith**

The Board:

1. Approved the Corporate Objectives 2025/26, subject to the amendments discussed and agreed.
2. Agreed that reports should demonstrate link directly to the Corporate Objectives.

## 18 PERFORMANCE REPORTING – QUARTER 3

The Board received a paper from the Head of Corporate Planning, Performance and Quality (Paper No. 25/14) providing a high-level summary of performance throughout Quarter 3. Ms Merson presented the paper, noting in particular the four Key Performance Indicators (KPIs) which were off target for this quarter, as well as work progressing in each area to seek improvement.

Mr Moore noted that it was also important to recognise that most areas were on target. Mr McConnell asked about the target relating to patients having their CPA documentation reviewed at six monthly intervals, and what were the factors within the process that were causing this. Professor Thomson advised that it was important to note that the CPA meetings were taking place at six monthly intervals, and this was seldom missed. However, the challenge related to the completion of the relevant paperwork to support the process, including checking for accuracy and updates. This was a shared process for both medics as well as administration staff, and a process map had been created to help to demonstrate any areas in which improvement was needed. She added that the new CPA process should also help to make improvement in this regard.

Ms Fallon commented on the target for patient BMI, and that there were some positives to be taken, especially around monitoring of newly admitted patients during their first 12 months in the hospital.

Mr Moore thanked Ms Merson for the paper, which was a helpful summary of performance, and focused attention on any areas which required improvement.

The Board:

1. Noted the content of report.

## 19 WHOLE SYSTEM INFRASTRUCTURE REPORTING: DO MINIMUM BUSINESS CONTINUITY OPTION

The Board received a report from the Acting Director of Security, Resilience and Estates (Paper No. 25/15) to summarise the TSH response to the new approach to Strategic Infrastructure Planning and Investment across NHSScotland. This new approach replaced the Property and Asset Management Strategy, with NHS Board now being required to submit a Programme Initial Agreement setting out a deliverable, whole system service and infrastructure change plan over the next 20 to 30 years.

Mr Hardy presented the paper which set out the first planning phase of this, this being the development

of a maintenance only business continuity plan based on a risk-based assessment of existing infrastructure, over a ten-year period. This initial submission was made on 31 January 2025, and the Board was asked to note the content and work progressed to date. He advised that it was expected that Scottish Government would review each submission made by NHS Boards and then hold feedback sessions with each Board after that. Moving forward, the next submission for 2025/26 would be due to be submitted to government by November 2025 and would be presented to the Board for agreement in advance of submission. He would link with Ms Smith in this regard.

**Action – Mr Hardy /Ms Smith**

Mr Jenkins added his support to this approach and also advised that he had reviewed the further detailed reporting in relation to each section of the risk-based assessment of essential maintenance needs, and this was available for information should this be helpful to the Board.

Ms Fallon commented that the report was helpful and asked about the capital allocation outlined for patient digital inclusion including the patient bank. This was an area of focus within the Patient Partnership Group. Mr Naught provided an update nothing that this was part of ongoing work with potential options under review. There was pilot work underway within the Transitions Service, which could possibly provide a patient banking function, or alternatively, existing providers may be able to do so. It would be necessary to integrate with other systems more widely.

In response to a query from Mr Moore about the possibility of future capital allocations becoming available, Mr Hardy advised that a position was awaited from Scottish Government. Mr McNaught cautioned that this was indicative, and that there was no guarantee of future allocations being made. Mr Jenkins added that Scottish Government would formulate planning on the basis of the submissions made across all 22 NHS Boards going forward.

The Board:

1. Noted the report, and that future reporting would return to the Board prior to the next submission due in November 2025.

## 20 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Acting Director of Security, Resilience and Estates (Paper No. 25/16) to confirm the updated position. Mr Hardy asked the Board to note that the projected completion date was 18 April 2025, and the progress of works towards this date.

Mr Moore noted the advice sent to Scottish Government to outline the projected financial spend to completion date and asked if any response had been received to date. Mr McNaught confirmed that there had ben no adverse response in this respect, and that Scottish Government were fully aware of the position.

Board Members noted this position, and the continuing efforts being made to bring the final stages of the project to completion.

The Board:

1. Noted this update in relation to the Perimeter Security and Enhanced Internal Security Systems Project and recognised that this was also an item for the Private Session of the Board Meeting.

## 21 AUDIT AND RISK COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 26 September 2024; as well as a summary report (Paper No 25/17) on the key areas of reporting and discussion at the meeting, which had taken place on 30 January 2025.

As Chair of the Committee, Mr McConnell highlighted that the Committee had reviewed the internal audit of the management of the Consultant Discretionary Points process, and well as undertaking a detailed review of its effectiveness during the September 2024 meeting. He noted that the January 2025 meeting had reviewed the internal audit relating to compliance with statutory and mandatory training, and that the approved minute would be submitted to the next meeting of the Board.

The Board:

3. Noted the content of the approved minutes 26 September 2024
4. Noted the update from the meeting held on 30 January 2025.

## 22 ANY OTHER BUSINESS

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

## 23 DATE AND TIME OF NEXT MEETING

The next meeting held in public would take place at 9.30am on Thursday 24 April 2025.

## 24 PROPOSAL TO MOVE TO PRIVATE SESSION

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

## 25 CLOSE OF MEETING

Mr Moore brought the session to a close, thanking everyone for their contributions.

*The meeting ended at 12noon*

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 | April 24 | A.O.B | Reporting template review around the monitoring report, and how to re-frame report template | M Smith | May 2025 | **October Update:** Review and align to governance arrangements for committees, and bring back to the Board.<br>**February:** Scheduled for Board Development Session on 1 May, alongside wider review of governance. |
| 2 | August 24 | Carers Story | Travel scheme to TSH – for carers | A Hardy | April 2025 | **December Update:** CMT requested further work in this respect to consider how best to support travel scheme, and to link this to the Carers' Strategy, to be further developed and return to CMT for consideration.<br>**February Update:** Update provided to February meeting of CMT, there is a review underway which includes gathering data on carer needs, which will help form the recommended way forward – further update to follow.<br>**April Update:** Report on agenda: Item 14 |
| 3 | August 24 | Quality of Care | - Quality of Care Reviews implementation | K McCaffrey | April 2025 | **December Update:** Associate Nurse Director progressed through Patient Safety Forum, and first Quality of Care walkround to commence in January 24.<br>**February Update:** Visit by Excellence in Care colleagues from NHS Forth Valley and took forward first informal walkround with NPD on 17 February. Further work linking to SPS with visit to HMP Polmont on 5 March, and will confirm date of first formal walkround. Plan to have four walkrounds a year. At meeting, Board noted update and agreed that work with other Boards to be helpful. |

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| | | | | | | **April Update:** March visit was re-scheduled to 23 April due to availability. Feedback following this visit can be provided verbally at board meeting. |
| 4 | August 24 | Whistleblowing | Agree new Exec Lead & re- launch Non Exec Champion role | S Wallace | April 25 | **October Update -** Refreshed approach re Speak Up Week progressed to raise awareness across organisation. Update on agenda as part of Board Improvement Plan. Establish change of Exec Leadership/ re launch Non-Exec role as next steps.<br>**February Update:** Work progressing, and reporting on agenda. Discussed and agreed that refreshed arrangements via Corporate Services should continue.<br>**CLOSED** |
| 5 | October 24 | Corporate Risk Register | -Consider Risk SD51 in context of project finalisation – and post completion period and how to re-frame risk<br><br>-Review Workforce Risks and potential to add to CRR – absence/ WTD etc.<br><br>- Update on progress of improvement work on management of SAERs | A Hardy | May/June 25 | **December Update:** This will be reviewed fully on completion of the project to understand risk the requirements to mitigate system failure. To return to Board in June.<br><br>**December Update:** This is under review and will return to the Board. Reviewed at Staff Governance Committee in February 25.<br>**February Update:** To return to Board in June.<br><br>**December Update:** Work remains ongoing to improve SAER process. Risk team will complete this work in the fourth quarter, once all outstanding SAER's are complete.<br>**February Update:** Discussed and agreed to add to Board Development Session agenda. Arranged for 1 May 2025. |

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| 6 | December 2024 | Business Continuity Plan – infrastructure | To submit report, and then bring to next meeting of Board | A Hardy | February 2025 | **February Update:** Reporting on agenda, and discussed and reviewed. **CLOSED** |
| 7 | February 2025 | Matters Arising | To check that Patients' Advocacy Service have allocated space within Skye Centre | G Jenkins | June 2025 | **April Update:** Review is underway with PCIT/Skye Centre Manger as well as PAS to identify needs and ensure that appropriate space can be made available to meet the needs of patients. |
| 8 | February 2025 | Matter Arising | To plan presentation regarding Non-Executive role for PPG | M Smith | July 2025 | **April Update:** Discussed and agreed with PCIT, who have also discussed with members of PPG to see if this would be helpful. There is agreement on this from the patients and it has been scheduled for PPG in July 25. |
| 9 | February 2025 | Chair's Update | TSH3030 – update to Board on this year's event | M Merson | April 2025 | **April Update:** on agenda as part of reporting: Item 13 |
| 10 | February 2025 | Chair's Update | NHSScotland Reform - arrange discussion and review at next Board Development Session. | M Smith | May 2025 | **April Update:** Arranged for 1 May session **CLOSED** |

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| 11 | February 2025 | CEO Update | Unscheduled Care – as reported to CMT and arrange for this to be added to Clinical Governance Committee agenda | M Smith/ L Thomson | May 2025 | **April 2025:** Reporting to Clinical Governance Group in April and to Committee in May as discussion item.<br>**CLOSED** |
| 12 | February 2025 | CEO Update | Provide an update to Board on roll out and impacts of Digital Inclusion Made Purple Pilot | R McNaught | June 2025 | **April Update:** Work in progress, and update to next Board meeting. |
| 13 | February 2025 | Female Service | Reporting to Board including governance arrangements and terms of reference for agreement | D Walker | April 2025 | **April Update:** Reporting on agenda: Item 8 |
| 14 | February 2025 | Staff Governance Report | Provide financial analysis aligned to staff absence to demonstrate impacts, and which areas most impacted for care delivery | S Wallace/ R McNaught | April 2025 | **April Update:** Reporting on agenda: Item 16 |
| 15 | February 2025 | Whistleblowing | Review and amend letter to Scottish Ministers, based on Board discussion and input, prior to submission. | M Smith | March 2025 | **April Update:** Letter revised by Whistleblowing Champion, and submitted to Scottish Government on 20 March (deadline being 31 March).<br>**CLOSED** |

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| 16 | February 2025 | Whistleblowing | Capture the routes through which concerns can be raised, and how made accessible to Staff i.e. business as usual and place whistleblowing route within that overall context, as well as whether meaningful data can be provided. | S Wallace | June 2025 | **April Update:** Work in progress, and update to next Board meeting. |
| 17 | February 2025 | Corporate Objectives | -Circulate refreshed and approved version to Board, and for website.<br>-Request Authors link their papers directly to the Corporate Objectives, each of which now had identifier reference. | M Smith/ All Directors | **April 2025** | **April Update:** Action completed to revise the Corporate Objectives and publish. All Directors asked to ensure that reports include direct link to Corporate Objectives, prior to submission to Board for April meeting. All reports on agenda should be compliant. |
| 18 | February 2025 | Whole System Infrastructure Reporting | Noted that next submission date will November 2025, so change made to Board workplan to bring to October Board Meeting | M Smith | Immediate | **April Update:** Workplan amended so reporting will be called for in October 2025.<br>**CLOSED** |

Last updated – 8 April M Smith

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

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| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 8 |
| Sponsoring Director: | Chief Executive Officer |
| Author(s): | Programme Director |
| Title of Report: | Project update for the National High Secure Forensic Healthcare Services for Women in Scotland |
| Purpose of Report: | For Noting |

## 1. SITUATION

This paper provides an update on the new development of National High Secure Forensic Healthcare Services for Women in The State Hospital (TSH).

## 2. BACKGROUND

TSH has been asked by Scottish Government to implement a proposal to deliver High Secure Services for Women in Scotland at TSH.

Strategically, this development supports 'The Independent Review into the Delivery of Forensic Mental Health Services in Scotland' published in 2021 (Recommendation 3); and 'The Mental Health and Wellbeing Delivery Plan 2023-25' published in November 2023 (Priority 8.1.2). This states 'During the lifespan of this Delivery Plan, develop a plan with stakeholders to deliver services in Scotland for women who need high secure care and treatment in the short and longer-term'.

The proposal is being developed in two phases:

i. develop and implement an **interim women's service model**,
ii. develop and implement an **outreach service model.**

Points i and ii above will be referred to as Phase 1, **The Interim and Outreach Service Model**. The timeline for completion and go live is **July 2025**.

iii. oversee the development and implementation of a capital development of the 'Harris Option', following the outcome, and preferred option, from a professional design team feasibility report.

Point iii above will be referred to as Phase 2, **The Medium- Longer Term Service Model**.

It is the intention that Phase 1 will integrate and co-locate with Phase 2 on its completion, therefore co-locating the three aspects of the patient's treatment journey into a central 'treatment hub' at The State Hospital. In January 2025, funding was confirmed by Scottish Government to progress both Phase 1 and 2, thereafter a Core Project Team (CPT) has been established to take forward planning.

## 3. ASSESSMENT

### GOVERNANCE

The establishment of a Women's Project Oversight Board (WPOB) is supported and agreed though the Corporate Management Team and The State Hospitals Board for Scotland. The POB is chaired by Mr. Stuart Currie, Non – Executive Director and meets monthly. Terms of Reference (ToR) were submitted for agreement at the first meeting in March and were subject to discussion and required further amendment. The revised ToR will be submitted to the April WPOB meeting for approval.

The CPT meets on a weekly basis and is chaired by the Programme Director.

The latest updates on progress of both phases are as follows:

### PHASE 1 UPDATE – INTERIM AND OUTREACH SERVICE

Clinical Governance

Referral and Admission Criteria:
Work to define the referral criteria and process is ongoing; this includes developing the clinical pathway for various needs of patients who for example may be under 18, have Intellectual Disabilities, involved in potential conflict resolution over their required level of security.

A workshop was held at The State Hospital on 1st April 2025 attended by representatives from The Orchard Clinic, Rowanbank, HMP Stirling and the Ayr Clinic. The Project Team from The State Hospital provided a presentation of the development of Women's Service at TSH, followed by a tour of Mull 3 and explanation of the planned adaptations. There was then helpful and collaborative discussion around the challenges of delivering care to this complex patient group. The CPT had the opportunity to learn from the experiences of the established services and there was particular discussion around:

- Managing potential issues of co-located male and female patients,
- Incident types, frequency and responder models,
- Delivering activity to small patient groups / avoiding isolation,
- Team cohesion, staff wellbeing and reflective practice,
- Staff training and skills maintenance

The CPT is also engaged with the Forensic Network for Scotland who are undertaking a review of 'Admission Criteria' to ensure there is alignment with the new service model.

Clinical Guidance:
The clinical team has established a weekly meeting to develop Clinical Guidance. A first draft of the clinical guidance will be delivered by the 6th May to allow time for finalisation prior the service opening in July 2025. Key areas of work are referral process, delivering structured activity, physical health needs, relational model, wellbeing and reflective practice.

Women's Physical Health Needs:
Health Centre staff have engaged with the GP service and are undertaking a joint review of additional needs and equipment required to either in the ward or the Health Centre. The current GP service provider has committed to providing additional GP sessions for the Interim Service. Details of these measures will be included within the Clinical Guidance document in May 2025

Ward Adaptations:
To ensure the environment is 'trauma informed', several additional ward adaptations are required alongside equipment. A small group, led by the Head of Estates will oversee these works and ensure compliance with relevant legislation.

The Programme Director is actively engaged with Health Improvement Scotland Quality and Assurance team on an inspection process for this area of the programme, this will incorporate elements from the WHO Quality Rights Toolkit and the Mental Health Built Environment Quality Assessment.

Safeguarding:
Social Work colleagues within TSH are liaising with counterparts in the local authorities in Scotland to assess and determine if further safeguarding measures, specific to women are required for the service introduction.

At this stage, a staff member from the Social Work team at TSH has been identified to support the service.

Staff Governance

**Leadership Roles** - The following senior leadership roles have already been appointed to:

- Consultant Psychiatrist
- Senior Charge Nurse
- Clinical Security Liaison Manager

**Nursing positions** - External recruitment has progressed in line with the timeline set:

- Charge Nurses (3wte),
- Registered Nurses (12.5wte) and
- Healthcare Support Workers (HCSWs) (11wte)

The target start date is Monday 23rd June 2025 to allow for required training over a period of four weeks. Currently, the 'patient ready' date is set for 21 July 2025.

To support recruitment to the service an internal process was agreed, to offer staff the opportunity to express an interest to move to the women's service in July. The timescale for expressions of interest was aligned to ensure that the number of 'movers' is known by the time external interviews take place.

Currently, there are sufficient numbers of applicants shortlisted for the Charge Nurse and HCSW positions.

Registered Nurses
Following the initial application stage there are 11 Registered Nurse applications shortlisted and internally there are 6 Registered Nurses who have expressed an interest to move to the women's service, therefore it may be that 12.5wte can be achieved for the women's service.

It is important to note that recruitment to the interim service does not adversely impact the existing staffing levels as presently there are 5.35 Registered Nurse vacancies. It is hoped that appointable candidates from this recruitment campaign could be 'shared' between both services as adverts, job descriptions and contractual arrangements allow for this. The ability to do this is now limited given the low number of shortlisted candidates.

Following completion of the interview process the opportunities available to mitigate this include:

- Re-advertise immediately.
- There has been a higher number of applications shortlisted for the Charge Nurse role. Any unsuccessful external candidates may be interested in a Registered Nurse position, this would be discussed with them as part of their feedback conversation.
- TSH proactively plan for recruitment and induction of newly qualified registrants in September / October time which would provide a new intake of registered professionals at this juncture.

- Consideration of the staffing model required on 'day one' as the actual number of patients for admission is currently unclear.
- In consideration of the timescale for newly qualified registrants, the uncertainty regarding the patient numbers, and there is a high number of HCSW applicants, there may be an opportunity to recruit additional, fixed term HCSWs to increase staffing into the service and adjust skill mix on an interim basis until more registrants can be appointed. This is being explored with the Director of Nursing.

Recruitment colleagues are working closely with Nursing Leads and the CPT to ensure that the process continues in accordance with the timeline and delivers the maximum possible appointments from this campaign. A further meeting is set for 22 April to review the outcome of the interview process.

In light of the foregoing the risk rating for this element of the service remains **'High' – this is noted in the Women's Service Risk Register.**

**Other positions** - The following positions have been advertised externally and are progressing with target start dates of 23rd June:

- Consultant Psychologist (closing 28 April)
- Clinical Psychologist (closing 10 April)
- Occupational Therapist (shortlisting stage)
- Housekeeper (closing 15 April)

Further updates will be provided in due course regarding the progress.

Training Plan:
A formal training plan has been developed for staff recruited to the interim service. Training will take place over a four week period commencing 23rd June 2025 and will include:

- Statutory/Mandatory training
- PMVA
- Trauma informed practice
- High Secure orientation.

On successful completion the Interim Service will be 'patient ready'.

Project Timeline:
An overall project timeline has been established and each element of service delivery contains further details of components and timescales towards 'the 'patient ready' date of 21July 2025. The project timeline has been reviewed by the WPOG at its meeting on 17 April.

**PHASE 2 UPDATE**

Following completion of the mini competition framework process, Thomson Gray have been appointed to conduct the feasibility study on each of the options from the High-Level Information Pack, these being:

- Redevelopment of Harris (including demolition and rebuild) with office accommodation on site
- As above with accommodation off site
- New build within existing perimeter (or opportunity to extend the perimeter).
- Extension to existing wards in Arran or Mull

A series of weekly meetings supported by stakeholder workshops have been undertaken and to date, work that has been completed includes:

- Schedule of Accommodation for Women's Service
- Schedule of Accommodation for Office space
- Benefits and constraints for each option

- Optimism Bias calculations
- Capital costings for each option

The final draft of feasibility report was submitted to the Core Project Team on 11 April 2025. The report will be presented to CMT for consideration and thereafter to the POB in May for approval. It will come to the State Hospitals Board private session in June 2025 after having gone through these governance routes.

## FINANCIAL UPDATE

Phase 1
Funding for Phase 1 has been committed by the Mental Health Directorate in year 2025/26. Verbal confirmation of recurring funding has also been given by Scottish Government with confirmation is writing anticipated as part of budget setting for 2026/27. This enabled the recruitment of a permanent staff group for the women's service.

A further £100k has been allocated for capital adaptations to Mull 3.

Phase 2
The allocation of £223,975k in 2024/5 for the Feasibility Study (Phase 2) includes:

Revenue Allocation: £73k
Revenue Spend: £41k
Under/(Over) Spend: £32k -The underspend in pay is a result of the costings being based on the team starting in post from December, with the exception of the project lead the project team did not commence until the end of January . £7k was allocated for travel costs (included within the revenue allocation of £73k), due to unforeseen circumstances these costs have not materialised yet. Remaining allocation will be carried forward into 25/26 for use.

Capital Allocation: £150k
Capital Spend: £37k
Under/(Over) Spend: £113k - Thomson Gray consultancy work, has been instructed and costs of £37k have been invoiced to date, the remaining allocation has been carried forward into 25/26 to cover the remaining costs that are anticipated.

## RISK REGISTER

A risk register has been developed jointly by the CPT and Risk department. Identified risks have been divided into the following themes:

- Workforce
- Finance
- Governance
- Clinical
- Environmental

Each risk is assessed weekly by the CPT and a report provided monthly to the WPOB. This process aligns itself to the TSH Risk Management Strategy and allows for the WPOB to escalate any risk to the Corporate Risk Register if required. Currently all risks are being managed through the POB governance process.

## STAKEHOLDER MAPPING AND COMMUNICATIONS PLAN

A comprehensive stakeholder mapping exercise and communications plan have been established by the CPT. These were endorsed by the WPOB in March and engagement with internal and external stakeholders is ongoing and supports the development of both phases of the project.

## EQUALITY AND DATA PROTECTION IMPACT ASSESSMENTS (EQIA/DPIA)

DPIA:
When TSH undertakes a project or makes changes to its services or changes the uses of personal data it is required to consider privacy 'by design and by default'. Following discussions with the TSH Information Governance and Data Security Officer, the project requires to have a DPIA in place. The DPIA should detail or reference documents that show the decision making process, in particular decisions that were taken around privacy issues. The CPT will undertake this work stream and assess timescales for development and provide an updated position to the WPOB meeting in May

EQIA:
In line with TSH policy, EQIAs have been developed for both phases of the project. During development of these, advice and guidance has been sought from Central Legal office to ensure compliance with duties contained within Human Rights and Equality Legislation. Both EQIA's will be submitted to the April WPOB for endorsement.

## 4. RECOMMENDATION

The Board is invited to note the status and progress of the project to deliver National High Secure Forensic Healthcare Services for Women in Scotland.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy /ADP** | This paper outlines the strategic direction, as led through Scottish Government and being taken forward by the State Hospital's Board. The Corporate Objectives 2025/26 proposed include this as a key focus of work. |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **1 Better Care**<br>f) Develop and implement an interim women's service model, in line with the project initiation. In the context of the State Hospital's Clinical Care Model, this will be an admissions ward, with equivalence of service provision to that of male patients in the existing admissions service.<br>g) Develop and implement an outreach service model for women from high security to medium security providers and the Scottish Prison Service. The aim of the outreach service is to work in partnership with service teams in the management of patients who may require admission, or who are displaying behaviours that could necessitate a high security referral.<br>h) Oversee the development and implementation of a capital development following the outcome, and preferred option, from a professional design team feasibility report. This development will create a dedicated care and treatment centre for women with tailored person-centred care packages aligned to the three phases of the Clinical Care Model: Admissions, Treatment & Recovery, and Transitions. |
| **Workforce Implications** | There are considerable implications as set out in the paper, as this service requires staff with specific skills required for this service, and also to consider any impact on existing staff. |
| **Financial Implications** | The funding is outlined in detail within the paper, representing additional revenue and capital out with existing budget. |
| **Route to Board**<br>Which groups were involved in contributing to the paper and recommendations. | Project Oversight Board to TSH Board (both public and private sessions). |
| **Risk Assessment**<br>(Outline any significant risks and associated mitigation) | The report sets out the initiation of work to develop this service, and the risk framework for the project will be reported through the Project Oversight Board, and to the State Hospitals Board. |
| **Assessment of Impact on Stakeholder Experience** | Reporting confirmed that a Stakeholder engagement plan has been developed by the Project Team and endorsed by the Project Oversight Board. The POB will be responsible for reporting in detail on impacts for all stakeholders, as the project develops. |
| **Equality Impact Assessment** | Equality Impact Assessments are in place for both phases of the project. Planned linkage with NHS Central Legal Office ensures compliance with Human Rights and Equality legislation. |
| **Fairer Scotland Duty**<br>(The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland | The development of the service will reduce current inequalities and gaps in service provision. |

| | |
|---|---|
| to consider how they can reduce inequalities when planning what they do). | |
| **Data Protection Impact Assessment (DPIA) See IG 16.** | Tick One<br>✓ There are no privacy implications.<br>□ There are privacy implications, but full DPIA not needed<br>□ There are privacy implications, full DPIA included |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 9 |
| Sponsoring Director: | Acting 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 (CRR).

## 2. BACKGROUND

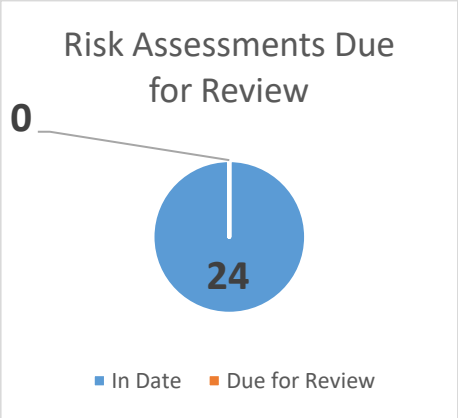
Each corporate risk has a nominated executive director who is accountable for that risk, as well as a nominated manager who is responsible for ensuring adequate control measures are implemented.

## 3. ASSESSMENT

### 3.1 Current Corporate Risk Register - See appendix 1.

### 3.2 Out of Date Risks

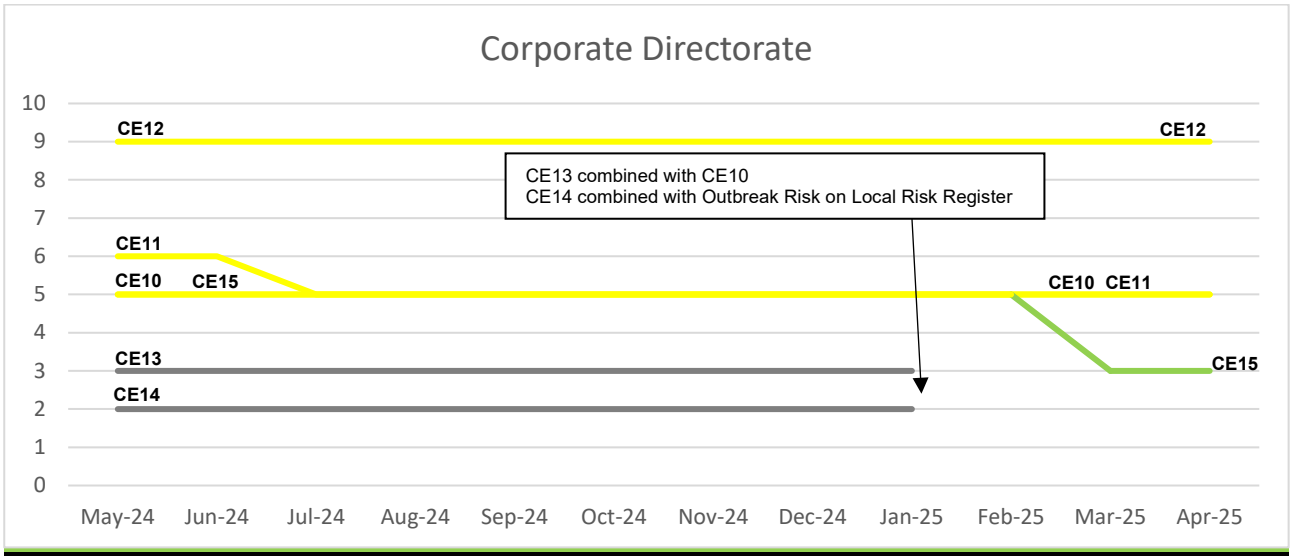
All risks are in date.

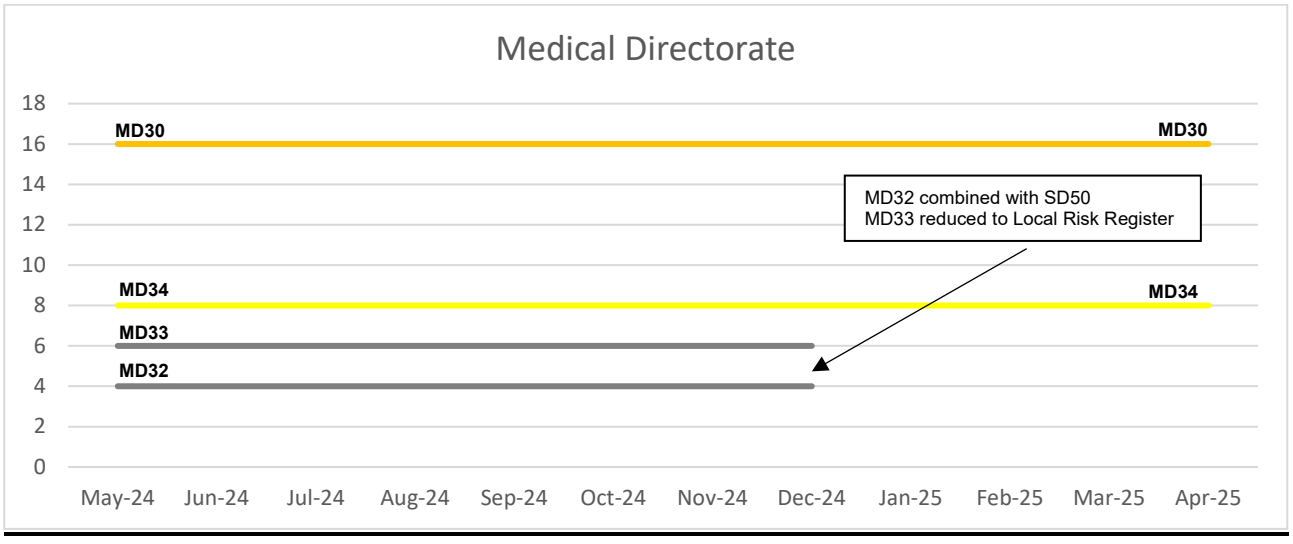


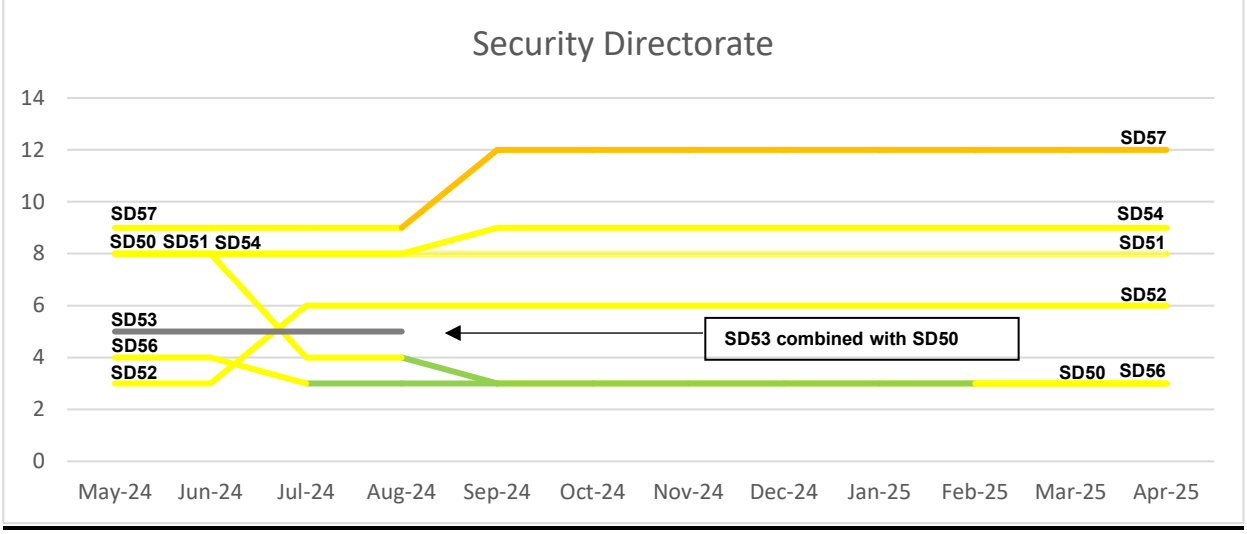
### 3.3 12 Month Risk Grading Assessment

| Likelihood | Impact/Consequences | | | | |
|---|---|---|---|---|---|
| | Negligible (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
| Almost Certain (5) | Medium (5) | High (10) | High (15) | V High (20) | V High (25) |
| Likely (4) | Medium (4) | Medium (8) | High (12) | High (16) | V High (20) |
| Possible (3) | Low (3) | Medium (6) | Medium (9) | High (12) | High (15) |
| Unlikely (2) | Low (2) | Medium (4) | Medium (6) | Medium (8) | High (10) |
| Rare (1) | Low (1) | Low (2) | Low (3) | Medium (4) | Medium (5) |

- Very High **17 -25**
- High **10 - 16**
- Medium **4 - 9**
- Low **1 - 3**




Security Directorate
14
12
10
8
6
4
2
0
SD57
SD50 SD51 SD54
SD53
SD56
SD52
SD53 combined with SD50
SD57
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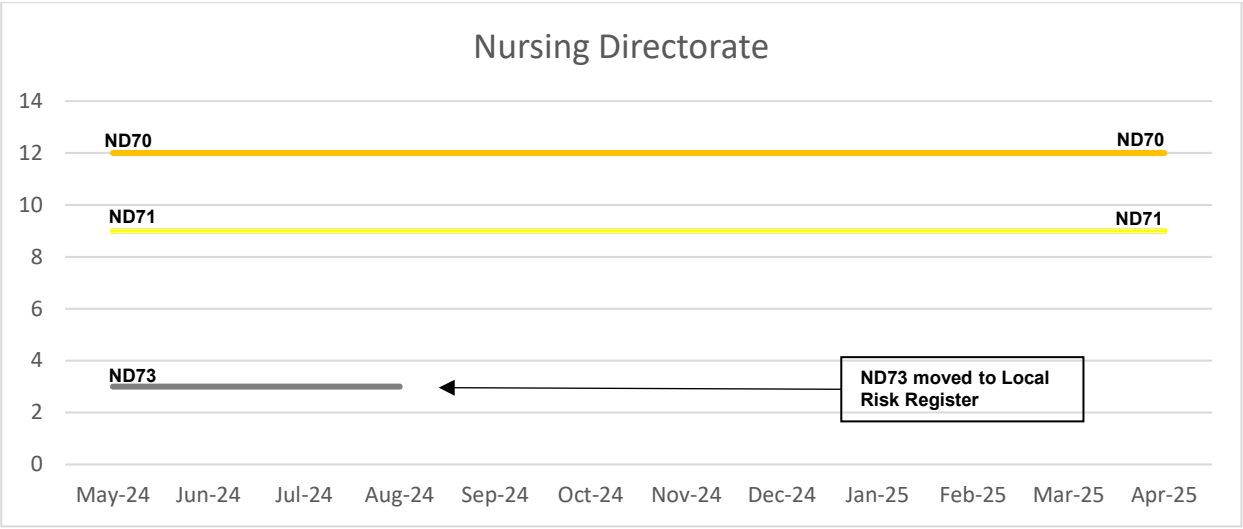
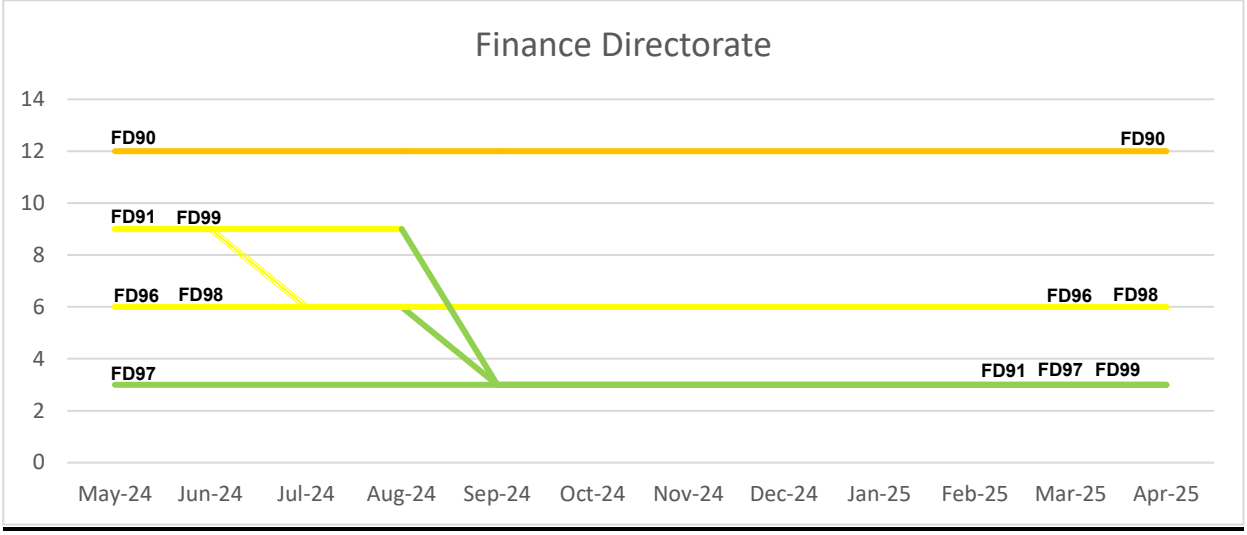
May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25


Nursing Directorate
14
12
10
8
6
4
2
0
ND70
ND71
ND73
ND73 moved to Local Risk Register
ND70
ND71
May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25


Finance Directorate
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FD90
FD91 FD99
FD96 FD98
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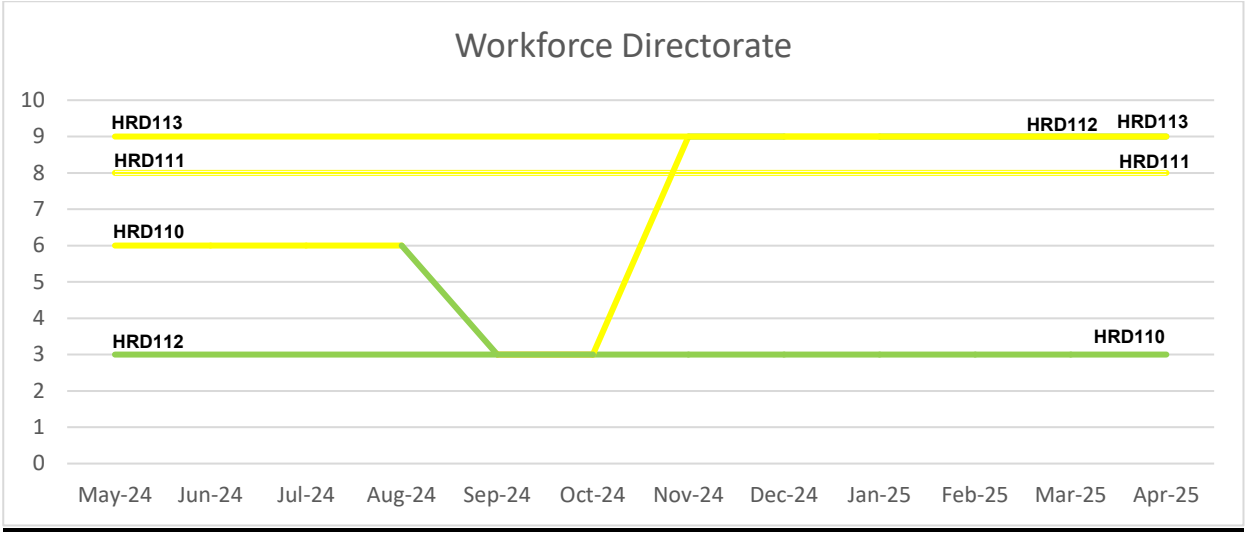
May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25




### 3.4 Update on Proposed Risks for inclusion on Corporate Risk Register (CRR)

Risk Assessments have been developed for the following risks relating to

- Staff Absence (inc. Breaching the Working Time Directive)
- Reduction in hours over 2025 and 2026

A further risk has been developed which relates to a potential delay to future PVG checks due to changes in the inclusion criteria across public bodies. Risk assessments are being reviewed by Risk Management and will be shared with the Chief Executive and relevant groups in due course.

### 3.5 Corporate Risk Register Development

The Risk Management Team are continuing to review and refresh the risk management process working closely with Directors across the services to continue to develop and refresh the Corporate Risk Register.

The following update informs the Board of the current ongoing development work with each Directorate and any changes made to the agreed level of risk over the last quarter.

**Current Progress:**

**Nursing Directorate**
Review of directorate is almost complete, with some risks being removed from Corporate and added to Local namely ND71 and ND73 with positive feedback received about new format. ND70 (staff resource) has been redesigned and awaits one last area of work, expected completion was March 2025 following Tableau staffing resource data going live however there has been no further update on the dashboard data. Follow up requests for completion date have been issued to allow this to be resolved.

**Workforce**
Workforce Directorate Review is nearing completion. See section 3.4 for updates.

**HRD112- Failure to Comply with Level 2 Refresher Training –** A reduction in PMVA Level 2 refresher training compliance was highlighted to Operational Management Team (OMT) in October 2024, and to reflect the reduction in training compliance the risk rating on the corporate risk register was subsequently increased from low to medium. Current figures are 88.7%, (target 90%). Risk remains at medium and will be reviewed at next review period with a view to reducing to Low if the figures remain within appropriate levels.

**Medical**
**MD30 Failure to Prevent or Mitigate Obesity –** Risk Management Team Leader has met with both the Lead Dietitian and Clinical Quality Facilitator. The next step is to review the broad range of data that is gathered on patient weight within TSH. The data will be analysed with a view to updating the overall focus of the risk. Preliminary discussions are looking at the number patients in each weight category, the number of patients moving between weight categories, the impact on a patients health within each weight category and the impact on admission patients/ patients who move on from TSH.

**Corporate**
All Corporate Risks aligned to the Chief Executive Officer (CEO) were reviewed in March 2025.

**CE15 Impact of Covid Statutory Inquiry** – Following review the level of the risk has been reduced to Moderate x Rare giving a Low grading. Reduction relates to a number of mitigating measures in place already and the impact the enquiry has had on TSH so far, should this impact increase, the risk may be increased again.

**CE11 Risk of patient injury** – Agreed to review risk at next interval with consideration to be given to the Directorate the risk sits under. Although an overall Corporate responsibility the other Directorates have more of a focus on managing the risk and gathering the data.

**CE12 Failure to utilise appropriate systems to learn from prior events internally and externally** – Risk to be combined with SD57 Adverse Event Review and Action Completion due to the similar hazards associated with the risk. At this point the risk will also be reviewed to ensure it covers all aspects of learning, appropriate grading and placement under the most relevant Directorate.

**3.6 High and Very High Risk – Monthly Update**
The State Hospital currently has 4 ‘High’ graded risks:

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

**Monthly Update:**
Obesity remains a challenge across the hospital and work is progressing to better measure the impact. Supporting Healthy Choices are the main driver for progressing and monitoring, with performance data now available that will assist in our measures.

Focus still remains on physical activity for our patients, and new medication is also in use to try to assist in weight loss. Review of risk underway as detailed in section 3.5

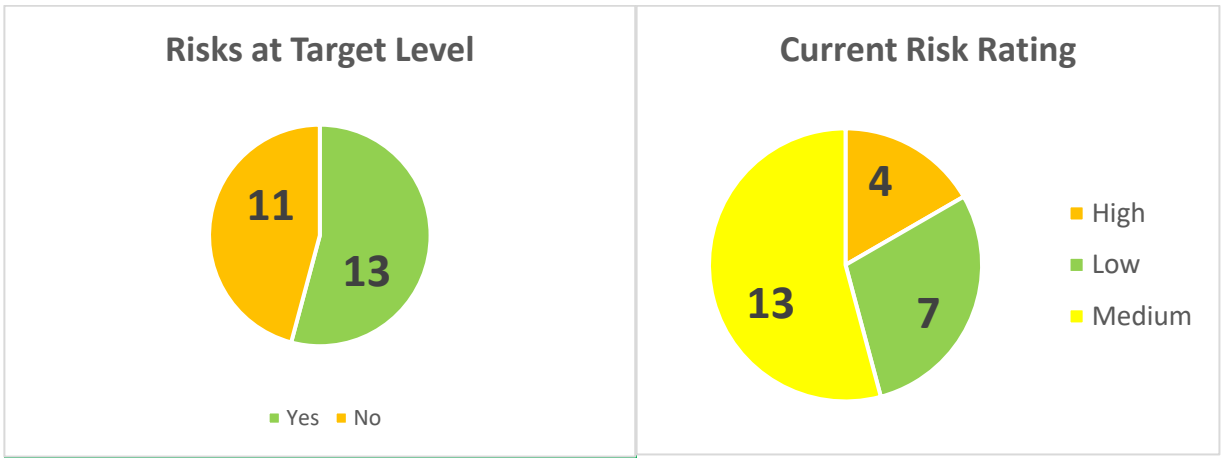
**Nursing Director: ND70: Failure to utilise our resources to optimise excellent patient care and experience.**

**Monthly Update:**
This risk remains as High. We are awaiting the finalisation of a Staff Resource Dashboard as outlined above

**Finance Director: FD90: Failure to implement a sustainable long-term model**
Risk was revised to reflect the national financial pressures as highlighted by SG communications in January and February 2024.

**Security Director: SD57: Adverse Event Review and Action Completion**
Increased to ‘High’ following a review in October 2024. The Risk and Resilience Team have identified the risk of adverse event reviews and resultant actions not being completed on time has increased following recent pressures within the team. The team will continue to review the risk and share the next steps that will reduce the risk to target level.

### 3.7 Risk Distribution




**Currently 13 Corporate Risks have achieved their target grading, with 11 currently not at target level.**
As per the TSH Risk Management Strategy, Low and Medium risks are tolerated within the organisation's risk appetite. While some of the Corporate Risks have not met their target level, they still remain within the agreed risk parameters. Ongoing focus remains 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, SD57 | MD30 | |
| Possible | FD91 | | CE12, HRD113, ND71, SD54, HRD112 | FD90 | |
| Unlikely | | | FD96, FD98, SD52 | MD34, SD51, HRD111 | |
| Rare | | | FD97, SD56, FD99,HRD110, SD50, CE15 | | CE10, CE11, |

**Review Periods:**

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

## 4. RECOMMENDATION

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

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy / ADP** | The report provides an update of the Corporate Risk Register. |
| **Corporate Objectives** | **1. Better Care**<br>d) Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk |
| **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**<br>Which groups were involved in contributing to the paper and recommendations | CMT and Audit and Risk Committee |
| **Risk Assessment**<br>(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**<br>(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<br>✓ There are no privacy implications.<br>☐ There are privacy implications, but full DPIA not needed<br>☐ There are privacy implications, full DPIA included |

## 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 | May 25 | Clinical Governance Committee | Monthly | - |
| Corporate ND 70 | Service/Business Disruption | Failure to utilise our resources to optimise excellent patient care and experience | Major x Likely | Moderate x Likely | Minor x Unlikely | Director of Nursing & AHP | Director of Nursing & AHP | May 25 | 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 & Performance Director | May 25 | Finance and Performance Group | Monthly | - |
| Corporate SD57 | Health & Safety | Failure to complete actions from Cat 1/2 reviews within appropriate timescale | Moderate x Likely | Moderate x Likely | Moderate x Unlikely | Finance & Performance Director | Head of Corporate Planning and Business Support | May 25 | Security, Risk and Resilience Oversight 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 | Major x Rare | Major Rare | Chief Executive | Board Secretary | May 25 | 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 | Extreme x Rare | Extreme x Rare | Chief Executive | Head of Risk and Resilience | May 25 | 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 | Negligible x Unlikely | Chief Executive | Head of Risk and Resilience | May 25 | Security, Risk and Resilience Oversight Group | Quarterly | - |
| Corporate MD 34 | Medical | Lack of out of hours on site medical cover | Major x Likely | Major x Unlikely | Major x Unlikely | Medical Director | Associate Medical Director | May 25 | Clinical Governance Committee | Quarterly | - |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate SD 51 | Service/Business Disruption | Physical or electronic security failure | Extreme x Unlikely | Major x Unlikely | Major x Rare | Security Director | Security Director | May 25 | 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 | May 25 | 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 | Moderate x Possible | Moderate x Rare | Security Director | Head of Estates and Facilities | May 25 | 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 | May 25 | Clinical Governance Committee | Quarterly | - |
| Corporate FD 96 | Service/Business Disruption | Cyber Security | Moderate x Likely | Moderate x Unlikely | Moderate x Unlikely | Finance and Performance Director | Head of eHealth | May 25 | Information Governance Committee | Quarterly | - |
| Corporate FD 98 | Reputation | Failure to comply with Data Protection Arrangements | Moderate x Likely | Moderate x Unlikely | Moderate x Unlikely | Finance and Performance Director | Head of eHealth/ Info Gov Officer | May 25 | Information Governance Committee | Quarterly | - |
| Corporate HRD 111 | Reputation | Deliberate leaks of information | Major x Possible | Major x unlikely | Major x unlikely | HR Director | HR Director | May 25 | HR and Wellbeing Group | Quarterly | - |
| Corporate HRD 112 | Health & Safety | Compliance with Mandatory PMVA Level 2 Training | Major x Possible | Moderate x Possible | Moderate x Rare | HR Director | Training & Professional Development Manager | May 25 | Clinical Governance 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 | May 25 | 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 CE15 | Reputation | Impact of Covid-19 Inquiry | Extreme x Likely | Moderate x Rare | Moderate x Rare | Chief Executive | Board Secretary | May 25 | Covid Inquiry SLWG | 6 Monthly | - |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate SD 50 | Service/Business Disruption | Serious Security Incident or Breach | Extreme x Likely | Moderate x Rare | Moderate x Rare | Security Director | Security Director | Aug 25 | Security, Risk and Resilience Oversight Group | 6 Monthly | - |
| Corporate SD 56 | Service/Business Disruption | Water Management | Moderate x Unlikely | Moderate x Rare | Moderate x Rare | Security Director | Head of Estates and Facilities | Aug 25 | Security, Risk and Resilience Oversight Group | 6 monthly | - |
| Corporate FD 91 | Service/Business Disruption | IT system failure | Moderate x Likely | Negligible x Possible | Negligible x Possible | Finance & Performance Director | Head of eHealth | Oct 25 | Finance and Performance 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 | Aug 25 | Information Governance Committee | 6 Monthly | - |
| Corporate FD 99 | Reputation | Compliance with NIS Audit | Major x Likely | Moderate x Rare | Moderate x Rare | Finance and Performance Director | Head of eHealth | Oct 25 | Information Governance Committee | 6 Monthly | - |
| Corporate HRD 110 | Resource | Failure to implement and continue to develop the workforce plan | Moderate x Possible | Moderate x Rare | Moderate x Rare | HR Director | HR Director | Oct 25 | HR and Wellbeing Group | 6 Monthly | - |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Report: | 24 April 2025 |
| Agenda Reference: | Item No: 10 |
| Sponsoring Director: | Director of Finance and eHealth |
| Author(s): | Senior Management Accountant |
| Title of Report: | Finance Report – to 31March 2025 |
| Purpose of Report: | For Noting |

## 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 2024/25 was submitted to SG and signed off, with a projected breakeven forecast, regular meetings between TSH and SG monitor progress against targets.

With regard to the capital spend programme, the Enhanced Security Project is noted to have a delayed
end date, as reported directly to the Board and notified to SG finance.

## 3 ASSESSMENT

### 3.1 Revenue Resource Limit Outturn

The annual budget of £50.284m is primarily the Scottish Government Revenue Resource Limit core and non-core allocations, and additional allocations as anticipated (increased capital charges for phase 1 Enhanced Security Project £0.445m plus depreciation of capitalised Enhanced Security Project £0.103m – as noted in 3.2).

| The State Hospital Annual Budget | £'000 |
|---|---|
| Total Budget | 50,246 |
| Plus depreciation of capitalised perimeter project assets | 103 |
| Plus depreciation of leased vehicles | 33 |
| Plus AME Provision | 344 |
| **Revised Budget for FPR** | **50,726** |

Additional revenue allocations were received in M11, these now being included in the budget

- Distinction Awards - £36k
- Agenda for Change Reform Costs - £866k
- Chair and non exec additional pay uplift - £29k

The draft March accounts show an under spend to date of £188k, Ward Nursing pressures and capital charges for depreciation of buildings being offset by a number of staffing vacancies, benefit of income from exceptional circumstances patients, and accrued allocations re staff rebanding.

### 3.2 2024/25 Budget

The 2024/25 budget template required by SG includes savings requirements of £1.3m (approx.3%). Individual directorate budget reviews established detailed plans for the achievement of a satisfactory level of savings being identified for the start of the year, with achieved savings being reported monthly - the savings target now noted as having been achieved (section 4. below).

The Capital budget for 2024/25 remains at a recurring level of £269k, with an additional £235k non-recurring capital allocated in Q4 of this year to purchase case conference room equipment and replacement x-ray machines.

### 3.3 Year-to-date position 2024/25 – allocated by Board Function / Directorate

| Directorate | Annual Budget £'k | Year to Date Budget £'k | Year to date Actuals £'k | YTD Variance | Budget WTE | Actual WTE | Comments |
|---|---|---|---|---|---|---|---|
| Cap Charges | 3,112 | 3,112 | 3,010 | 102 | 0.00 | | Overspend of £103k from depreciation of perimeter fence is offset with a benefit of £205 resulting from the reveral of previous year's impairment of fixed assets |
| Central Reserves | 1,405 | 1,405 | 1,027 | 378 | 0.00 | 0.00 | RRL phased to period 12 and released as required, an element of RRL remains unused due to the restrictive ways that it can be utilised. |
| Chief Exec | 2,558 | 2,558 | 2,558 | (0) | 25.17 | 25.93 | Social Work SLA has been uplifted to reflect additional costs |
| Finance | 3,316 | 3,316 | 3,857 | (540) | 29.18 | 31.91 | ECP invoices now processed for full period. Injury benefits are a current pressure of £176k, with pressure of £220k driven by M365 being unfunded nationally for Q3 and Q4, increased service contracts costs and staff funded from the strategic allocation which is not uplifted in line with pay awards. |
| Misc Income | (100) | (100) | (249) | 149 | 0.00 | 0.00 | Benefit from current ECP charges, to be offset against pressure resulting from previous years ECP charges being cleared (pressure sits within finance) |
| Human Resources Directorate | 1,162 | 1,162 | 1,136 | 27 | 16.30 | 16.29 | This is resulting from an underspend in training and vacancies across the directorate |
| Medical | 3,679 | 3,679 | 3,562 | 116 | 20.95 | 18.24 | Driven by an underspend in pharmacy drugs and vacancies |
| Nursing And Ahp's | 26,836 | 26,836 | 27,359 | (523) | 404.13 | 418.33 | see below for detailed narrative from nursing directorate |
| Security And Facilities | 8,278 | 8,278 | 8,279 | (0) | 123.63 | 115.81 | Vacancies across the directorate are contributing to underspend, offset against pressure of £214k from increased utilities costs, in addition to current pressure there has been £32k allocated from reserves against the utilities pressure in previous months |
| Allocations remaining for y/e | 480 | | | 480 | | | Final AME confirmation, funding re depreciation |
| | **50,727** | **50,247** | **50,539** | **188** | **619.36** | **626.51** | |

**Nursing & AHPs** (as provided from Nursing Directorate)

In keeping with previous submission reports, The main contributors to nursing overtime costs continue to be increases to the daily operating model as a consequence of clinical acuity (including boarding patients for physical healthcare requirements), vacancies and sickness absence. In addition to the aforementioned, the hospital has been operating with one extra ward since July 2024 to provide care for a patient with specific risk and clinical needs.

As noted in previous updates, pro-active-recruit campaigns to manage the Band 5 nursing vacancy gap have demonstrated success and following Board approval, work was undertaken in January 2025 to employ an additional ten Healthcare Support Workers. This recruitment campaign resulted in additional staff onboarding mid-March 2025. Furthermore, a recruitment event was also undertaken in March 2025 with a specific focus on supporting the opening of an interim women's service at the hospital. Shortlisting for this new service has now taken place and interviews are due to commence week beginning 14 April 2025.

Robust attendance management processes and regular reviews of employee relation cases remain in place. Likewise, monthly Senior Charge Nurse (SCN) performance reviews continue ongoing. These meetings enable supportive discussions with SCNs around effective roster management, effective use of allocated funding, and robust oversight of non-pay related spending. Going forward there will be consideration of combining monthly HR/absence review and finance meeting to allow SCNs a more robust understanding of financial implications of insufficient staffing (e.g. from either poor rostering and/or absence).

The Director and Associate Director of Nursing continue to meet monthly with the Head of Finance to ensure the Nursing Directorate remain on track to meet all financial savings and requirements.

### 3.4 Financial pressures / potential benefits.

**Pressures:**

Ward Nursing (hightlighted in regular monthly meetings with SG for potential consideration)

- Boarding out costs – patients being treated at acute hospitals with staff in attendance (to date £483k)
- High risk patient on enhanced care requiring 4 staff members for both day shift and back shift and 2 staff members on night duty – 6 July to 28 February £1,230k
- Escorted transfer of female patient to Wales – cost of staff in attendance £1.7k

M365

- Q1 and Q2 have been recharged by NSS and are included in the position. The costs of Q3 and Q4 have created a pressure of £52k in M11.

Energy and Inflation Increases

- The unused prior year accrual has been carried forward to provide against anticipated pressure in 2024/25, with a reserve in place as well. This has been highlighted as a risk to SG, with £332k additional budget allocated. Reserves have been utilised against these costs which has resulted in a pressure of £65k in M11.

AFC Reform

- The reduction in 37.5 hour working week – underway by ½ hour for full-time (pro rata for part time staff) – has been funded in 24/25. Further reductions will be made to reduce the working week down to 36 hours by April 2026.
- Adjustment to a number of posts – yet to be determined – from band 5 – band 6. An allocation has been received to offset the anticipated cost pressure that is likely to arise in 25/26, for which any excess will be carried forward into 25/26 against future costs and reported accordingly in 24/25.
- Training – protection is in place against these costs as per national guidance.

PAIAW – (payment as if at work)

- Funding continues to be held as a reserve for the current year and released monthly to cover the costs incurred. The majority of the prior years PAIAW arrears have now been paid, there are a few outstanding and due to be paid in the coming months. These costs have been covered by an accrual from previous financial years.

**Benefits:**

Travel & Training

- Less spend has continued to be required following covid, with most meetings and some training online.

## 4 ASSESSMENT – SAVINGS

Savings targets are generally phased evenly over the year (twelfths) – and equate to £1.3m (3%).
With adjustment re nursing for accuracy of tracking (phased July to March).
As shown in the table below savings are very slightly over achieved to date.

| Directorate | Annual Target £k | Savings Achieved £k | Suplus/ (Shortfall) £k |
|---|---|---|---|
| Chief Exec | 74 | 40 | (34) |
| Finance | 101 | 117 | 16 |
| Human Resources Directorate | 25 | 25 | 0 |
| Medical | 74 | 74 | 0 |
| Nursing And Ahp's | 828 | 1,003 | 175 |
| Security And Facilities | 233 | 82 | (151) |
| | **1,335** | **1,341** | **6** |

It should be noted that of the Hospital's budget only 14% of costs are non-pay related, certain boards also treat vacancy savings, as recurring savings, we class ours as non-recurring.

## 5 CAPITAL RESOURCE LIMIT

The recurring capital allocation is £269k, with capital projects planned and agreed through the Capital Group. Additional funding has been granted by SG for 24/25. Additional non-recurring capital budget has been granted of £235k

With regard to the Enhanced Security Project allocation, there are elements of delays in the Project – now expected to be completing by financial year end '25, with first lot of retention spend now delayed until following year rather than current year, with final retention two years later.

| Capital CRL 2024/2025 | Annual Plan £k | YTD Spend £k |
|---|---|---|
| **Perimeter Security** | | |
| Securitas (previously Stanley Security Solutions LTD) | | 34 |
| Thomson Gray LTD | | 191 |
| TSH Staffing | | 164 |
| Income re Covid recharges, sale of radios etc. | | -63 |
| **Perimeter Security Total** | **350** | **326** |
| | | |
| **Capital** | | |
| IM&T | | 221 |
| Other | | 201 |
| Thomson Gray | | 30 |
| **CapitalTotal** | **269** | **452** |
| | | |
| **Additional Capital granted Dec 24** | | |
| IT/AV equipment for case conference rooms | 82 | |
| replacement x-ray machines | 153 | |
| **Additional Capital Total** | **235** | |
| | | |
| **Total CRL** | **854** | **778** |

## 6 RECOMMENDATION

The Board is asked to note the content of the report – highlighting the following position and forecast –

**Revenue**
The draft year-end position is an under spend of £188k, with ward nursing costs remaining the key pressure, with savings target on track.

**Capital**
The budget is fully committed for the year.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy / ADP** | Monitoring of financial position |
| **Corporate Objectives** | **3. Better Value** –<br>a) Meet the key finance targets set for the organisation and in line with Standard Financial Instructions.<br><br>c) Deliver all Scottish Government financial budget and resource reporting and monitoring requirements for NHSScotland national matters, through Board Chief Executive, Director of Finance and Human Resource Director groups. |
| **Workforce Implications** | No workforce implications – for information only |
| **Financial Implications** | Reporting on financial outturn and budgetary compliance |
| **Route to Board**<br>Which groups were involved in contributing to the paper and recommendations. | Senior Management Accountant<br>CMT<br>Partnership Forum<br>Board |
| **Risk Assessment**<br>(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**<br>(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<br>√ There are no privacy implications.<br>□ There are privacy implications, but full DPIA not needed.<br>□ There are privacy implications, full DPIA included. |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 11 |
| Sponsoring Director: | Medical Director |
| Author(s): | Associate Medical Director/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 22nd January 2025 until 31st March 2025.

**Table 1**

| | Admissions & Acute | Treatment & Recovery | Transitions | ID | Total |
|---|---|---|---|---|---|
| Bed complement | 24 | 48 | 24 | 12 ID beds (and 12 contingency beds) Total 24 | 120 (+ 20 additional unstaffed beds) |
| Beds in use | 22 | 48 | 20 | 12 + 2 ID surge | 104 |
| Admissions | 8 (external)<br>0 (internal) | 0 (external)<br>2 (internal) | 0 (external)<br>1 (internal) | 1 (external)<br>2 (internal) | 9 (external)<br>5 (internal) |
| Discharges/Transfers | 4 (external)<br>2 (internal) | 1 (external)<br>1 (internal) | 1 (external)<br>0 (internal) | 1 (external)<br>2 (internal) | 7 (external)<br>5 (internal) |
| Bed occupancy as at 31/03/2025 | 91.7% | 100% | 83.3% | 116.7% (ID beds) | 86.7% (available beds)<br>74.3% (all beds) |

Please note that in total there were 104 patients as of 31 March 2025. 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).

**Table 2 – Time between admission and referral**

| Date | 6 weeks or less | More than 6 weeks | Total Number |
|---|---|---|---|
| 21/01/2025 – 31/03/2025 | 9 | 0 | **9** |

All patients were admitted within 6 weeks of referral.

There are 11 patients identified for transfer (10 MMI and 1 ID), 4 of whom have been fully accepted. No patient has been waiting longer than 12 months. There have been two excess appeals won. Full details are available but not included for reasons of patient confidentiality.

There is one patient currently in TSH under the Exceptional Circumstances clause; he was admitted on 26/07/24.

**b) Bed Occupancy since start of new Clinical Model**

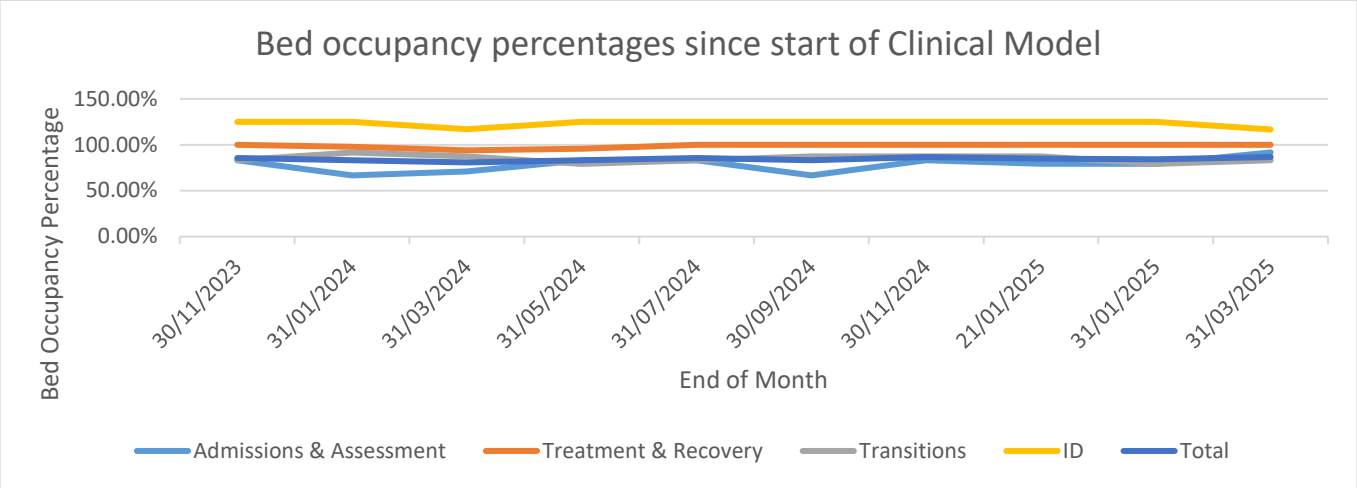


**Table 3 Bed Occupancy by Service and in Total**

| Service | 30/11/23 | 31/01/24 | 31/03/24 | 31/05/24 | 31/07/24 | 30/09/24 | 30/11/24 | 31/01/25 | 31/03/25 |
|---|---|---|---|---|---|---|---|---|---|
| **Admissions & Assessment** | 83.30% | 66.70% | 71% | 83.30% | 83.30% | 66.7% | 83.3% | 79.2% | 91.7% |
| **Treatment & Recovery** | 100% | 97.90% | 94% | 95.80% | 100% | 100% | 100% | 100% | 100% |
| **Transitions** | 83.30% | 91.60% | 87.50% | 79.20% | 83.30% | 87.5% | 87.5% | 79.2% | 83.3% |
| **ID** | 125% | 125% | 117% | 125% | 125% | 125% | 125% | 125% | 116.7% |
| **Total** | **85.8%** | **83.3%** | **80.8%** | **83.30%** | **85.8%** | **83.3%** | **86.7%** | **84.2%** | **86.7%** |

Table 3 shows an increase of patients in the admissions service, which reflects the greater number of admissions as outlined in table 1.

### c) TSH Contingency Plan

Following the new Clinical Model being implemented, SOPs for surge bed contingency planning has been agreed through the Clinical Model Oversight Group. There exists 2 agreed SOPs. One allows for use of surge beds within the Intellectual Disability Service solely at night/when patients have defined time in the rooms. The other for patients who would remain in the surge bed within the Intellectual Disability Service day and night. No patients are currently identified given current bed availability and recent patient flow, it would be possible though to identify patients with clinical teams rapidly should this be required. These arrangements have never been used.

### d) Forensic Network Capacity

We receive a weekly forensic estate update report from the Forensic Network to aid patient flow (Appendix 1). As of 11 April there were 6 empty beds (Male Mental Illness and Male Intellectual Disability). The Orchard Clinic has temporarily reduced its capacity for over one year by 7 beds for urgent repairs.

Please note there are few beds in medium or low security.

## 3 ASSESSMENT

The current bed situation within TSH is manageable. 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.

The Orchard Clinic's temporary closure of 7 beds for urgent work is causing further pressure across the forensic estate.

## 4 RECOMMENDATION

The Board is asked to note the report.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy / ADP** | The report supports strategy within the hospital, and all associated assurance reporting. |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **1. Better Care**<br>b) Tailor the Clinical Model to better reflect the graduated clinical and security steps for patient progression on their care and treatment pathway.<br><br>i) Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events<br><br>p) Collaborate with the Forensic Network in the delivery of quality care guidance and standards applicable to the Forensic Mental Health Environment.<br><br>r) Support the development of a national framework for collaborative working in the delivery of forensic mental health services across NHSScotland.<br><br>**2. Better Health**<br>f) Ensure that patients have a seamless transition from the State Hospital to other care providers as part of their care pathway when clinically appropriate. This will align with the aims and ambitions of medium secure provision and other treatment pathways. |
| **Workforce Implications** | N / A |
| **Financial Implications** | N / A |
| **Route To Board**<br>Which groups were involved in contributing to the paper and recommendations | Board requested as part of workplan |
| **Risk Assessment**<br>(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**<br>(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<br>√ There are no privacy implications.<br>□ There are privacy implications, but full DPIA not needed<br>□ There are privacy implications, full DPIA included |

| W/c 7 April 2025 | High Secure | | Medium Secure | | | | | | | Low Secure | | | | | | | | | | | | | | Private Sector | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TSH Male MI | TSH Male LD | Orchard Clinic Male | Orchard Clinic Female | Rohallion Male | Rowanbank Male | Rowanbank Female | National LD Male | National LD Female | Beckford Lodge Male | Beckford Lodge Mixed Forensic Rehab | Bellsdyke Male | Bellsdyke Female | Leverndale Male | Leverndale Female | Leverndale Male LD | Rohallion Male | Blair Unit Male (as at w/c 31.03.25) | Blair Unit Female (as at w/c 31.03.25) | Stratheden Male (as at w/c 10.03.25) | Woodland View Male | Kirklands Hospital Mixed ID (as at w/c 31.03.25) | Lynebank Male ID (as at w/c 31.03.25) | Strathmartine Male ID | Ayr Clinic Male | Ayr Clinic Female | Surehaven Male (as at w/c 31.03.25) | Surehaven Female (as at w/c 31.03.25) |
| Bed capacity | 108 | 12 | 31 | 2 | 31 | 56 | 6 | 8 | 4 | 15 | 12 | 12 | 6 | 38 | 5 | 9 | 24 | 31 (reduced due to works) | 2 | 12 (2 beds in lodge) | 8 | 2 | 10 | 8 | 36 | 20 | 15 | 6 |
| No. of beds in use | 89 | 14 | 29 | 2 | 28 | 52 | 3 | 7 | 2 | 13 | 12 | 10 | 4 | 37 | 4 | 8 | 20 | 43 | 2 | 11 | 8 | 0 | 8 | 8 | 36 | 20 | 14 | 6 |
| No. empty beds | 6 | -2 | 0 | 0 | 3 | 4 | 3 | 1 | 2 | 2 | 0 | 2 | 2 | 1 | 1 | 1 | 4 | 0 | 0 | 1 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 |
| No. available beds | 6 | 0 | 0 | 0 | 1 (rehab) | 1 acute | 3 | 0 | 1 | 2 | 0 | 2 (1 for recall CORO bed) | 2 | 0 | 1 | 0 | 1* | 0 | 0 | 0 | 0 | 0 | 2 Regional | 0 | 0 | 0 | 0 | 0 |
| No. on waiting list for access to service | 0 | 0 | 6 | 1 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 34 | 0 | 2 | 1 | 2 | 0 | 4 | 1 | 2 | 0 | 0 | 3 | 4 | 2 | 0 |
| Current location of individuals on waiting list for access to service | N/A | N/A | 4 x TSH, 1 x Rehab ward in England & 1 x prison | 1 x Prison | 2 x TSH | 1 x Rohallion | N/A | N/A | Courseview | N/A | N/A | N/A | N/A | Rowanbank & OOA | | Ayr Clinic and Rowanbank | 1 x medium secure | 1 x medium secure; 1x prison | N/A | 2 x IPCU, 1 x private sector, 1 x medium secure in England | 1 x Rowanbank Clinic | 2 x medium secure | N/A | N/A | 2 x IPCU & 1 x acute | 2 x acute, 1 x IPCU & 1 x low secure | 2 | N/A |
| No. on waiting list currently placed out of area | 0 | 0 | 3 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 18 | 0 | 1 | 0 | 1 | 0 | 2 | 1 | 2 | 0 | 0 | 1 | 2 | 0 | 0 |
| No. of patients on transfer list for lower security settings | 11 | 0 | 2 | 1 | 5 | 16 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| No. of patients on transfer list for higher security settings | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| No. of patients on transfer list for community or other services | 0 | 0 | 9 | 0 | 0 | 2 | 0 | 0 | 0 | 2 | 0 | 3 | 0 | 14 | 2 | 2 | 9 | 5 | 0 | 0 | 0 | 0 | 4 | 0 | 3 | 3 | 2 | 0 |
| No. of delayed discharges | 0 | 0 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 3 | 1 | 2 | 4 | 5 | 0 | 3 | 1 | 0 | 3 | 0 | 0 | 0 | 0 | 0 |
| No. of patients on transfer list fully accepted for transfer | 4 | 0 | 0 | 0 | 4 | 11 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | 4 | 2 | 0 |
| No. of admissions in the last week | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| No. of those admissions that were an emergency | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| No. of discharges in the last week | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Any foreseen potential issues this week in terms of capacity | | | | | | High levels of enhanced obs and clinical activity (2 x LSR and 1 x recall) | | x 1 bedroom out of commission requires major repairs | | | | 3 patients living in trial flat full-time | 1 patient living in trial living flat full-time | | | 1 x bed used as therapy room | * 2 beds unavailable due to outstanding repair works | These numbers include bed usage across the IPCU and support from other wards in the hospital. Due to works one bed reduced at present but surge capacity also removed. | | | | Review of beds being undertaken by the service. | | | | | |

Total Bed Availability Across Forensic Estate **22**

**Monitoring of Prison Transfers**

No. of patients awaiting assessment/transfer from prison **11** 5 x referral to Orchard Clinic, 2 x Rowanbank Clinic, 4 x TSH

No. of cases on Problematic Case Register **2**

| Bed Position Weekly Report Guidance |
| --- |
| Bed capacity |
| No. of beds in use |
| No. empty beds |
| No. available beds |
| No. on waiting list for access to service |
| Current location of individuals on waiting list for access to service |
| No. on waiting list currently placed out of area |
| No. of patients on transfer list for lower security settings |
| No. of patients on transfer list for higher security settings |
| No. of patients on transfer list for community or other services |
| No. of delayed discharges |
| No. of patients on transfer list fully accepted for transfer |
| No. of admissions in the last week |
| No. of those admissions that were an emergency |
| No. of discharges in the last week |
| Any foreseen potential issues this week in terms of capacity |

| |
|---|
| The number of beds the service has |
| The number of beds that are currently being used |
| The number of beds that are empty in the service (number of beds in use + number of empty beds should add up to bed capacity, if not please explain in foreseen potential issues) |
| The number of beds that are available for use (this may not be the number of beds that are empty e.g. due to damages, booked beds for patients on the waiting list etc.) Any issues affecting the number of beds |
| The number of patients on the waiting list for access to the service |
| The current location of individuals on the waiting list for access to the service (e.g. high/medium/low secure, |
| The number of patients who are on the waiting list but are currently accessing out of area beds in another |
| The number of patients on the waiting list for transfer to conditions of lower security |
| The number of patients on the waiting list for transfer to conditions of higher security |
| The number of patients on the waiting list for discharge back to community or other services |
| The number of patients clinically ready for discharge but cannot leave hospital e.g. due to bed availability, |
| The number of patients who have been referred and fully accepted by service referred to |
| The number of patients that have been admitted in the last 7 days |
| The number of patients who were admitted as an emergency rather than a planned admission |
| The number of patients that have been discharged in the last 7 days |
| Any foreseen challenges relating to bed use within your service over the coming week. (For example, reasons as to why admissions cant take place despite empty beds; staffing problems; beds closed for repairs; delays |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 12 |
| Sponsoring Director: | Director of Nursing and Operations |
| Author(s): | Director of Nursing and Operations/ Director of Workforce |
| Title of Report: | Nursing Resource Strategy 2025/26 |
| Purpose of Report: | For Noting |

## 1. SITUATION

The purpose of this report is to provide the Board with an overview on the direction of the Nursing Resource Strategy for 2025/26 in response to a number of internal and external influences.

## 2. BACKGROUND

Safe staffing and the elimination of Day Time Confinement (DTC) remain organisational priorities within the State Hospital. The Board agreed to over recruit an additional 10 wte Band 3 staff in Dec 2024. Following this decision there have been a number of resourcing requirements which have impacted on the original purpose of the over recruitment, which was to create stability in the nursing workforce, enable the elimination of DTC and rebase the number of nursing staff required for each service.

In response, the Director of Nursing and Operations felt it was important to reflect and restate, the nursing resource position to the Board with a strategic overview for the coming year.

The main influencing factors are:-

- The Health and Care (Staffing) (Scotland) (2019) Act
- The e-Rostering system (Optima)
- The Reduce Working Week
- The introduction of the women's service
- The elimination of DTC
- Attendance Management

## 3 ASSESSMENT

### The Health and Care (Staffing) (Scotland) (2019) Act

At the end of April 2025 the Board will be required to submit its first annual report regarding compliance with the legislation. It is not anticipated that NHS Boards will be fully compliant at this stage but are expected to make steady progress and implement clear plans to ensure compliance. There is a separate report detailing the current position for The State Hospital (Agenda Item 15).

However, from the perspective of the nursing resource strategy the compliance with the duties within this legislation are at the very heart, and the ongoing reports provide the evidence regarding progress made.

**eRostering**

A key element for Nursing Resource over the coming year is to progressively step towards full utilisation of Optima (eRostering), which will then allow broad benefit realisation of these systems.

Key challenges, which are recognised nationally, remain around the compatibility of the system (which will require greater flex in our processes) and the lack of interface (which accounts for extensive double keying of crucial information).

However, full commitment to the adoption of Optima, and the overcoming of these challenges, will allow a wholesale move from current manual practices, with Optima supporting rota design and delivery, all changes being completed electronically including shift swaps and recording of TOIL and also by supporting the full use of SafeCare (which will provide oversight of all wards staffing, allowing for electronic movement of staff to balance staff demands.) These aspects will address many of the challenges highlights form the recent internal audit process.

The timescale for looking at the current rotas was affected by the national phasing in of the final reduction to a 36hr week. We agreed that as this would require a change in current rostering practices it was in the best interest of staff to do this, once we were given the go ahead for the final reduction to be implemented. The key milestones for NHS Board are October 25 to define the preferred 36hr model, with implementation from April 2026.

The combination of these two aspects, should fundamentally change our approach to resourcing for the better.

**The Reduced Working Week**

The timetable for the implementation of the reduced working week as part of the Agenda for Change pay deal was determined by the Scottish Government.

In February 2025, the Cabinet Secretary for Health and Social Care wrote to all boards advising that the final reduction of 1hr to the 36 hr week was to be implemented by 1 April 2026. All Boards were to have an agreed plan by 1 October 2025, both of which should be agreed by Partnership.

In response, we have taken the opportunity to fully review the shift arrangements for nursing staff. Through staff engagement we want to understand what is important to people, as well as ensuring that service provision is optimised. This will also allow a greater focus on health and wellbeing, work life balance and compliance with working time regulations, along with minimising the resource required to support safe staffing.

Staff engagement sessions supported by HR, management and partnership, were held throughout March and the Short Life Working Group is being stood up to discuss the potential shift options that may be available. It is hoped that staff can then be presented with a number of options as our agreed route forward.

The identification of a single simplified roster will also enable The State Hospital to fully utilise the rostering functions of the Optima System.

**The Women's Service**

The Scottish Government asked the Board to develop an interim plan for female patients whilst longer-term plans are developed through site feasibility study. The expectation is that The State Hospital will be in a position to admit women by July 2025.

Whilst already working on the longer-term solution the timescale for the interim model was not immediately anticipated when the nursing resource paper was submitted to the Board in Dec 2024.

**The Impact on the additional Band 3 staff**

Following Board approval, the recruitment of the 10wte staff progressed with a good uptake, successfully recruiting 7.4wte staff and commenced employment on the 17 March 2025.

However, as the timescales for the women's service was developed in January, no sooner had we recruited the fixed term staff but the recruitment to the permanent positions required for the interim women's service got underway. As the band 3 staff are fixed term they are entitled to also be considered for any permanent posts which become available during the term of their fixed term contract. HR contacted the staff to advise them and asked those wishing to be considered for a permanent post either within the women's service or to back fill current substantive staff wishing to move to the new service. Of the 9.4wte, all expressed an interest in a permanent post. This could mean that once fully inducted the impact of the additional staff may be seen in the women's service, and slightly delay original purpose which was to rebase the current staffing numbers to eliminate DTC.

It was therefore agreed that once all the band 3 interviews were concluded any appointable staff who have not been successful in securing a permanent post be offered a 12 month fixed term contract to fulfil the original approved plan to over recruit the 10wte band 3 staff.

Another impact is on the ability to measure the impact of the additional band 3 staff, as this would potentially be neutralised by the introduction of the women's service staff. Having previously agreed to provide the board with an update following the year assessment period, it is important that the introduction of the women's service does not artificially skew the data collected.

**Sustained support and governance**

With the introduction of the women's service immediately following the over recruitment of band 3 staff we potentially see an influx of new staff to the State Hospital. It is crucial that this onboarding is carefully managed and that there is robust support and oversight for the new staff and service.

In order to ensure the safe onboarding of these staff within a high secure environment they will need to be placed for a time within the current services as well as spending time with current female service providers across the forensic estate. This will take careful planning and coordination with a focus on safety and security, wellbeing, connection, a sense of belonging to the organisation and team development.

There is also a need to ensure there is a good mixture of skills and expertise in all areas within the State Hospital, therefore following the recruitment to the permanent positions there is a need to ensure there are not high concentrations of new staff in any given area and balance the leadership across all wards.

Recognising there may be periods when there are no or low numbers of female patients, it is important to have an agreed plan for those periods to ensure staff remain feeling valued and connected. It is suggested that an agreed anchor ward/service for staff be identified to ensure that relationships are developed and familiarity with a second clinical area. This also ensure that the staffs' skills continue to be maintained and developed.

Supervision and mentorship for the staff within this new service will provide an additional layer of support and the timely identification of any issues. In particular as we are introducing an outreach element to this service which will be a new way of working for many staff.

**The elimination of DTC**

Following on from the work of the DTC Short Life Working Group, there are a number of forums that are responsible for taking forward the key pieces of work to eliminate DTC from practice.

These fora are mainly:
- The Patient Safety Group
- Workforce Governance (WG)
- Organisational Management Team (OMT)
- Activity Oversight Group (AOG) – input from Service Leadership Teams & Skye Centre
- Clinical Model Oversight Group (CMOG)

In a bid to pull the work of these fora together, the Director of Nursing as chair of OMT held a meeting with leads/chairs from each to look at how we could pull the strands of the work into one overarching report. The meeting allowed consideration of the remit of the former DTC SLWG group and agreed the need to convene a DTC Oversight group. The oversight group consists of the chairs of these fora to pull the various strands of work together into one comprehensive report and to agree and overarching plan to move this to a business as usual.

The Clinical Quality department provide the data and support required for the above forums to analyse and to identify actions required to address this very complex issue. Input also provided from Professional Leads and Business Manager with support from partnership.

The DTC Oversight group reports to the Clinical Governance Group and Clinical Governance Committee. Operationally this group also reports to OMT and escalates to CMT as required. Once in a position to move DTC to Business Continuity a paper will be presented to CMT for approval.

**Data led decision making**

The current nursing resource data shows that the transitions service is consistently working with the lowest core staffing establishment, data also indicates that the Transitions service is disproportionately impacted by DTC. In order to address this and recognise fully the additional rehabilitative requirements of this service it has been agreed that 8 of the 10wte band 3 staff will be allocated to transitions to enable them to have a 5:5:2 roster pattern, rather than 4:4:2.

This will stabilise the Transitions service by giving them the consistent numbers they need based on the retrospective run rate of the previous 12 months, to fulfil their function and improve the patients' experience. It also enables us to measure the impact of the additional resource in eliminating DTC. The remaining additional staff will be allocated to target the issues affecting the Admissions and Assessment and Treatment and Recover services. The ID service does not require any additional staff, given already healthy staff establishment of 6:6:3 roster pattern.

DTC Oversight group provides the necessary oversight for the multipronged approach required to address this complex issue. It is also responsible for overseeing the transition from current operational oversight to a business as usual model.

This issue is not unique to the State hospital, but has also been experience by the other high secure hospitals in England. As part of the high secure collaborative a team from the State hospital have visited Rampton Hospital to learn how they eliminated day time confinement and will present their findings to the oversight group for consideration.

**Absence Management**

The persistently high sickness absence rate is also a clear contributing factor to the incidences of DTC. Through the Workforce Governance structure, there are a number of measures in place continuing to work towards a reduction in the sickness absence rate to within the 5% target. There continue to be regular oversight meetings with the Chief Executive, Director of Workforce and the

Director of Nursing and Operations.

**Timeline for the Nursing Resource Strategy**

In the next 6/12 of 2025 ( April-Sept 25)

- No change to current rosters
- Staff engagement to identify key principles require for new single roster
- Continued focus on reducing sickness absence
- Open the women's service

In the following 6/12 ( Oct 25 - March 26)

- **Women's service**
  Assess the implementation of the women's model

- **RWW**
  By Aug/Sept 25 the plan will have been agreed in partnership regarding implementing the final 1hrs reduction. This requires to be fully implemented by April 2026

- **H&CSA and e-Rostering**
  The 2nd H&CSA annual report will be due by end April 2026. Agreed single roster, which will enable the full utilisation of the e-Rostering functions

- **DTC**
  Elimination by October 2025

## 4. RECOMMENDATION

The above report provides an overview of the multiple factors influencing nursing resourcing over the coming year and the resulting strategy sets a clear direction and a comprehensive approach to the governance required.

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

| | |
|---|---|
| **How does the proposal support current Policy / Strategy /ADP** | Supports the delivery against the Workforce strategy/ ADP and compliance with the HCSA. |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **Better Care**<br>a) Implement the Annual Delivery Plan and the Medium-Term Plan, aligning the organisational aims and direction to the health priorities set out in Scottish Government Policy, aligning to NHS Reform across NHSScotland.<br><br>c) Eliminate the use of Day Time Confinement to all but very exceptional circumstances.<br><br>d) Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk.<br><br>e) Ensure the principles of the rehabilitative care are applied optimising opportunities for meaningful patient activities, educational development and occupational development across all service areas.<br><br>f) Develop and implement an interim women's service model, in line with the project initiation. In the context of the State Hospital's Clinical Care Model, this will be an admissions ward, with equivalence of service provision to that of male patients in the existing admissions service.<br><br>g) Develop and implement an outreach service model for women from high security to medium security providers and the Scottish Prison Service. The aim of the outreach service is to work in partnership with service teams in the management of patients who may require admission, or who are displaying behaviours that could necessitate a high security referral.<br><br>i) Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events.<br><br>l) Monitor the use and recording of restrictive practices (including seclusion practice and use of soft restraint kits) in accordance with Mental Health legislation and the definitions published by the Mental Welfare Commission.<br><br>**2. Better Health**<br><br>b) Continued improvement of the physical health opportunities for patients.<br><br>c) Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient.<br>d) Address the overall social wellbeing issues for patients undergoing treatment. |

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| | **3. Better Value**<br>a) Meet the key finance targets set for the organisation and in line with Standard Financial Instructions.<br><br>**4. Better Workforce**<br>a) Development and delivery of the three-year Workforce Plan 2025/28 within the context of the planning framework and guidance from Scottish Government.<br><br>b) Continue to support and build partnership working so that this is embedded across the organisation.<br><br>c) Deliver and monitor staff resourcing aligning to the Health and Care (Staffing) (Scotland) Bill (2019) across the State Hospital, and in conjunction with the local delivery of the national e-rostering programme, through the Workforce Governance Group.<br><br>d) Maximise workforce sustainability through delivery of the State Hospital's Recruitment and Retention Strategy, through modern, inclusive recruitment practice and continued development of a supplementary workforce.<br><br>e) Promote and deliver a framework of wellbeing within the framework of a Staff and Volunteer Wellbeing Strategy<br><br>i) Sustain a safe working environment for staff with a focus on risk management across all aspects of the organisation.<br><br>l) Review and action absence related issues and prioritise support mechanisms and staff wellbeing to provide staff and line managers with the support required; and where absence is required, support staff to return to work at the earliest opportunity. Strengthen leadership and develop positive culture.<br><br>m) Continue to support training and development for all staff at every level across the organisation. |
| **Workforce Implications** | Noted in paper |
| **Financial Implications** | No Additional finance implications at this time. It is anticipated that funding will be provided centrally to offset the gap created by the reduced working week. |
| **Route to Board**<br>Which groups were involved in contributing to the paper and recommendations. | Details work overseen through Clinical Governance and Staff Governance |
| **Risk Assessment**<br>(Outline any significant risks and associated mitigation) | none |
| **Assessment of Impact on Stakeholder Experience** | Staff engagement underway |

| | |
|---|---|
| **Equality Impact Assessment** | Not required |
| **Fairer Scotland Duty**<br>(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<br>√ There are no privacy implications.<br>□ There are privacy implications, but full DPIA not needed<br>□ There are privacy implications, full DPIA included |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 13 |
| Sponsoring Director: | Medical Director |
| Author(s): | Head of Corporate Planning, Performance and Quality<br>Head of Clinical Quality<br>Corporate Planning Support Manager<br>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. The report highlights activities in relation to Quality Assurance (QA) and Quality Improvement (QI) outlining 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

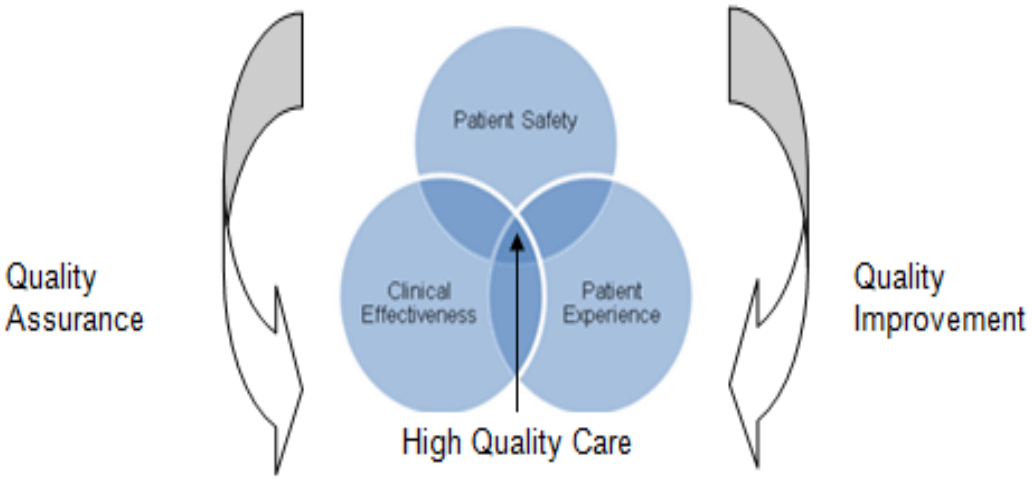
## 2. BACKGROUND

Quality assurance and improvement in TSH links to the Clinical Quality Strategy 2024 – 2029. This strategy was presented to TSH Board in August 2024 and adopted as TSH current strategy to progress clinical quality. The Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. The vision for the outcome of this Strategy is to improve the experiences of care and health provided to our patients by working together to deliver quality care and support that is person centred and free from harm**.** It outlines the following aims to ensure the organisation remains focussed on delivering our quality vision.

With our quality vision aims being to:

- Deliver safe, effective and person-centred care based on available evidence and best practice.
- Achieve demonstrable improvements in outcomes including the patient experience.
- Demonstrate meaningful involvement of patients, carers, volunteers and all other stakeholders* in quality assurance and improvement activities.
- Provide assurance to Scottish Government and stakeholders, around safe systems and continuous improvement to quality of care whilst addressing any health inequalities in our patient population.
- Develop a culture of ongoing learning and continuous improvement.

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.




## 3. ASSESSMENT

The paper outlines key areas of quality improvement and assurance activity over the reporting period, these include:

- The monthly report from the analysis of variance analysis tools and completion of three clinical audits:
  - RMO Contact with patients Audit.
  - Unvalidated Progress Notes Audit.
  - Nursing Progress Note per Shift Audit.
- An update on the work of the QI Forum including current training in progress for Q4 and TSH3030 proposal.
- An update on the actions associated with the Realistic Medicine portfolio.
- An overview of the 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 /ADP** | The quality improvement and assurance report support the Quality Strategy |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **1. Better Value**<br>d) Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk.<br><br>k) Deliver a programme of Infection Control related activity in line with all national policy objectives.<br><br>l) Monitor the use and recording of restrictive practices (including seclusion practice and use of soft restraint kits) in accordance with Mental Health legislation and the definitions published by the Mental Welfare Commission.<br><br>n) Embed the principles of Realistic Medicine, through the Realistic Action Plan for 2025/26.<br><br>**2. Better Health**<br>c) Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient.<br><br>g) Ensure the organisation is aligned to the values and objectives of the wider mental health strategy and framework for NHSScotland. |
| **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**<br>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**<br>(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**<br>(The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on | This will be part of the project teamwork for any of the QI projects within the report. |

| | |
|---|---|
| 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<br>x There are no privacy implications.<br>□ There are privacy implications, but full DPIA not needed<br>□ There are privacy implications, full DPIA included |

## QUALITY ASSURANCE AND IMPROVEMENT IN TSH FEBRUARY/MARCH 2025

## 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 21-25 audits carried out. These aim to provide feedback and assurance to a range of stakeholders that clinical policies are being adhered to. All clinical audit reports contain recommendations to ensure continuous quality improvement and action plans are discussed at the commissioning group.

There have been 3 audits completed and actioned through the Commissioning Group:

- RMO Contact with Patients
- Unvalidated Progress Notes Audit
- Nursing Progress Note per Shift Audit

Following a request from TSH Board, the Clinical Quality Department have developed a master audit sheet (Table 1) reflecting the outcomes of all the local audits that have recently taken place and colour coded the compliance for each ward. Green shows that improvement areas are very minimal (and they should celebrate their excellent adherence), amber shows that the ward has been given some improvements that require to be actioned and red means we have concerns that there is a system/process failure within the ward for that audit.

Table 1: Master Audits

| Arran 1 | Lewis 1 | Arran 2 | Arran 3 | Lewis 2 | Lewis 3 | Mull 1 | Mull 2 | Iona 1 | Iona 2 | Iona 3 |
|---|---|---|---|---|---|---|---|---|---|---|
| Medication Trolley Audit (to ensure that medication is kept in alphabetical order and dose low to high as per guidance) | | | | | | | | | | |
| | | | | | | | | | | |
| Medicine Fridge Audit (all medicine fridges within the hospital will be fit for purpose and temperature regularly monitored) | | | | | | | | | | |
| | | | | | | | | | | |
| HEPMA Audit (to ensure that medicines are being administered as per the Safe Use of Medications Policy | | | | | | | | | | |
| | | | | | | | | | | |
| PMVA Post physical Audit (to ensure staff are completing the PPIA, NEWS and PRN forms) | | | | | | | | | | |
| | | | | | | n/a | n/a | n/a | | |
| Unvalidated progress notes audit (to ensure all progress notes are validated within 7 working days to make them a legal entry) | | | | | | | | | | |
| | | | | | | | | | | |
| Nurse Progress Note Audit (to ensure all patients have one nursing entry per shift as per NMC guidance) | | | | | | | | | | |
| | | | | | | | | | | |

### RMO Contact with Patients

The hospital has a standard that all patients should be seen by their RMO at least once per month. The Q4 data gave us excellent assurance that this standard is being met. Although there was one patient that had not been seen, there was evidence that the RMO had attempted to see them, but

the patient was in isolation at the time. There were another 2 instances where the patient had been seen but the progress note had not been validated (we included this as compliant with the standard, but reminders given that progress notes should be validated as soon as they are completed as this makes them a legal entry).

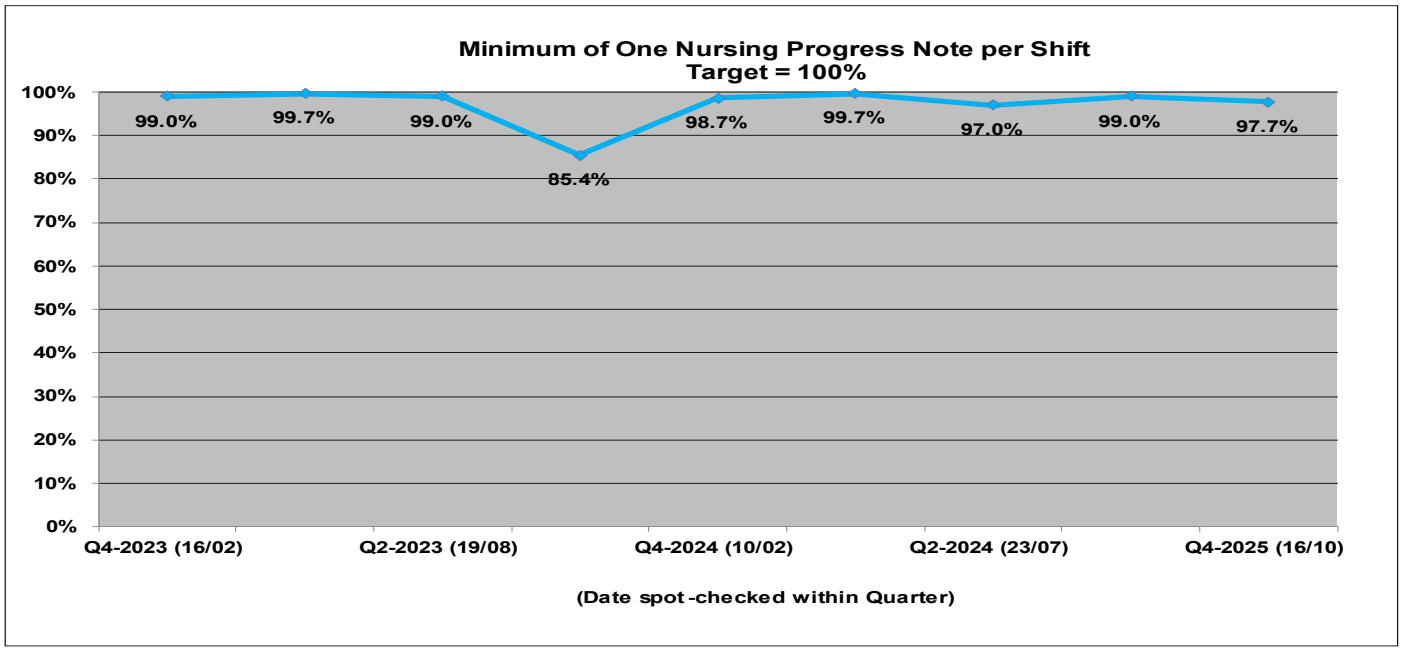
**Unvalidated progress notes**

The Q4 audit provided excellent assurance that progress notes are being validated within an acceptable timeframe. This is important to the organisation as the record is not seen as a legal entry until validated. On a monthly basis, there will be at least 9,500 progress notes made by nursing alone and this increases to approximately 11,000 when we include all other disciplines. For the month audited there were 52 progress notes that had not been validated. This is an increase from the previous audit and the Heads of Departments have been sent the data to address with their teams.

**Nurse Progress Note per Shift**

The Q4 audit provided excellent assurance that at least one nursing progress note for the patient is being entered on each shift. This is a slight decrease from the Q3 data where there was compliance of 99%. Q2 had a compliance of 97%.

Chart 1




Audits prepared and ready to be presented to Commissioning Groups include the PMVA Physical Intervention Audit and the Consent to Treatment Audit.

Table 2 -Hospital Wide Variance Analysis (VAT) Flash Report – CPA's

Date: March 25

**Overview and areas of good practice**

This report refers to all annual and intermediate CPA reviews held across the hospital in March 25.

The monthly VAT report is split as follows:

| March 25 | Annual | Intermediate | Total | VAT completion | MDT attendance |
|---|---|---|---|---|---|
| Admission | 0 | 3 | 3 | 98% | 76% - increased from 57% in Feb 25 |
| Arran T & R | 2 | 0 | 2 | 100% | 81% - increased from 50% in Feb 25 |
| Lewis T & R | 0 | 4 | 3 | 96% | 71% - increased from 60% in Feb 25 |
| ID | 2 | 0 | 2 | 100% | 69% - decreased from 71% in Feb 25 |
| Transition | 2 | 2 | 4 | 100% | 69% - increased from 57% in Feb 25 |

In addition, data on individual Admission CPAs and Discharge CPAs will be reported to the appropriate service.

All interventions showed random variation with continued good report provision. Overall attendance increased from 57% to 70% during March 25.

Overall VAT form completion increased from 93% to 99%. Medical completion increased from 54% to 94% with improvements in all interventions.

Security attendance increased from 20% to 80%.

**Areas of concern**

Nursing – Key Worker attendance decreased from 67% to 53%. Overall nursing attendance at Annual and Intermediate reviews was 93.3% - on one occasion the VAT form was not competed. A detailed breakdown has been forwarded to the Lead Nurses and Associate Nursing Director.

Carer attendance decreased from 33 % to 13%. The median for this sits at 30% however In March 24 carer attendance was also 13%.

**Any challenges with the systems that are being addressed**

Work has started on pulling pathway data direct from RiO – with testing scheduled for May, June and July 25.

## QUALITY IMPROVEMENT

### QI Forum

The QI Forum continues to meet on a six weekly basis focusing on its purpose to champion, support and lead quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. A significant area of leadership and planning for the QI Forum is the development and co-ordination of TSH3030.

### TSH3030

The State Hospital is once again holding its award winning Quality Improvement (QI) initiative - TSH3030 (pronounced “TSH thirty thirty”), offering teams the opportunity to take forward a QI project for 30 minutes a day for 30 days. This will run from Thursday, 1 May to Friday, 30 May 2025. Team applications closed on the 7 April 2025 with 20 teams from across TSH registering to take forward projects. The proposed projects for improvement fall under the following three broad themes - staff health and well-being, patient health and well-being and TSH processes

Throughout May, TSH3030 teams will work with a QI mentor to develop their projects. The QI Forum will host QI Cafes weekly throughout the 30 days to provide teams with support. Teams will be asked for their ‘word of the week’, a mid-way QI project poster to demonstrate their learning and a final poster which will summarise their QI journey, this will be judged alongside the other final projects. A QI celebration event – the TSH3030 Oscars will be held in June to recognise the improvements that teams have achieved.

### QI Capacity Building

QI Essential Training third cohort finished with five members of staff completing the course. Staff feedback from attending this course was they enjoyed the course, learning more around QI methodology and using the tools available to better understand systems and process around their projects.

Scottish Improvement Leaders Programme (ScIL) training is ongoing with two members of TSH staff currently undertaking this programme as part of cohort 46/47, which is due to conclude in June 2026. ScIL cohort 50 commenced in November 2024 with a further two staff members currently undertaking this programme.

One member of staff is currently undertaking the Scottish Coaching and Leading for Improvement Course (ScILP); this will be the last course being provided by NES due to structure changes, whereby this course will move to online training.

### Realistic Medicine

The Realistic Medicine Team have received the provisional funding offer for 2025/26 to support embedding the principles of Realistic Medicine within the State Hospital. The Realistic Medicine 2025/26 action plan was positively received at the Clinical Governance Group in February 2025 and was submitted to the Scottish Government on the 17 March 2025 and currently awaiting feedback.

As part of the national Realistic Medicine agenda, a case study document is being developed by the Scottish Government showcasing work being completed across Scotland. The State Hospital submitted a case study on the work around the introduction of BRAN (Benefits, Risks, Alternatives & Doing Nothing) questions which has been accepted. The publication of the case study booked will be later in 2025.

## 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 2025, 14 guidance documents have been reviewed. There were 12 documents which were considered either not relevant to TSH or were overridden by Scottish guidance and one document which was circulated for information and awareness. The final guidance from SIGN requires an evaluation matrix to be completed in relation to prevention and remission of Type 2 Diabetes.

Table 3: Evidence of Reviews

| Body | Total No of documents reviewed | Documents for information | Evaluation Matrix /action required |
|---|---|---|---|
| SIGN | 3 | 1 | 1 |
| National Institute for Health & Care Excellence (NICE) | 11 | 0 | 0 |

There are currently six additional evaluation matrices which have been outstanding for a prolonged period. The two Scottish Government documents regarding quality prescribing are nearing the end of the process and are due to be tabled at the next Medicines Committee meeting for final agreement and sign off. Completion of the HIS standards has proved problematic due to the availability of staff – much of this process has had to be done with individuals completing the evaluation matrix and then circulation for agreement when updated. This is hoped to be completed and tabled at the next PHSG at the end of April. The remaining three evaluation matrices have started the review process and will be progressed within prioritisation of current workloads.

Table 4: Evaluation Matrix Summary

| Body | Title | Allocated Steering Group | Current Situation | Publication Date | Projected Completion Date |
|---|---|---|---|---|---|
| Scottish Government | Quality prescribing for antidepressants – A guide for improvement 2024-2027 | Medicines Committee | Review group met early January 2025. Identified the need to complete some further work to ensure members are fully informed prior to making a final decision re two recommendations. Aim to take to Medicines Committee early May for sign off | August 2024 | May 2025 |
| Scottish Government | Quality prescribing for Benzodiazepines and z-drugs – A guide for improvement 2024-2027 | Medicines Committee | Gap analysis review group met in February 2025 and began completion of evaluation matrix. Currently reviewing draft with aim to take to Medicines Committee early May for sign off. | August 2024 | May 2025 |

| Body | Title | Allocated Steering Group | Current Situation | Publication Date | Projected Completion Date |
|---|---|---|---|---|---|
| HIS | Ageing and frailty standards for the care of older people | Physical Health Steering Group | Ongoing issues re availability of review group members. Two meetings took place February 2025. Further meetings were arranged with members who could not attend. Currently awaiting feedback re bladder and bowel health. Thereafter aim to take to PHSG for agreement and sign off in May 2025. | November 2024 | May 2025 |
| SIGN | British guideline on the management of asthma | Physical Health Steering Group | Evaluation matrix created. Initial review to be completed by Practice Nurse/GP and thereafter CQ Facilitator to arrange review group meeting. Practice Nurse/GP having to prioritise within current workload and time restraints | November 2024 | August 2025 |
| SIGN | Asthma: Diagnosis, monitoring and chronic asthma management | Physical Health Steering Group | Evaluation matrix created. Initial review to be completed by Practice Nurse/GP and thereafter CQ Facilitator to arrange review group meeting. Practice Nurse/GP having to prioritise within current workload and time restraints | November 2024 | August 2025 |
| NICE | Overweight and obesity management | Physical Health Steering Group | To be progressed in absence of current Scottish guidance (publication anticipated March 2027). Evaluation matrix created. CQ Facilitator to arrange review group meeting whilst prioritising within workload. | January 2025 | August 2025 |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

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|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 14 |
| Sponsoring Director: | Acting Director of Security, Estates, Risk and Resilience |
| Author(s): | Acting Director of Security, Estates, Risk and Resilience |
| Title of Report: | TSH Carers Travel Scheme |
| Purpose of Report: | For Decision |

## 1. SITUATION

Following the presentation of a patient's story to the Board last year, it was mentioned by a carer that they struggled to get to the hospital, due to location and limited public transport options. On hearing this the Board asked for the hospital to look at this situation, and to identify if this was a major concern or a recurrent issue.

## 2. BACKGROUND

In the past public transport links to and from the hospital were stronger. Not only was there improved links, but there was also a SACRO (charity) bus that ran weekly from Glasgow and Edinburgh. Due to increasing costs and limited usage of the services, the transport links to the hospital have decreased leaving few options other than to travel by car.

Within the local area there is a train station in the nearby village (Carstairs) with a limited train timetable from both Glasgow and Edinburgh, approx. 3 times per day. The main local train line runs though Lanark from Glasgow and Edinburgh running 2 services every hour. Also, from this station there is public bus transport that passes the front door of the hospital, meaning that transport links are available but limited. There are other train stations located near the hospital, in Bathgate and Hamilton but are approx. 30 – 40 minutes from the hospital with no public transport bus link.

The Person-Centred Improvement Team (PCIT) work closely with carers. There are options for those that struggle to attend, especially for those who have mobility difficulties. The PCIT team have budget to utilise; where additional support is required. An approved taxi company can provide transportation.

There was a request of the Board to look at options the hospital may potentially take forward from our existing transport infrastructure.

These options were explored:

a) **Available vehicles:**

The hospital has two vehicles that can be used to transport the public plus an ambulance used to transport patients with mobility issues on a bed. These vehicles form part of the fleet of vehicles used to transport patients out with the hospital. These vehicles are used based on operational and clinical need and at times can all be out of the hospital. These vehicles also facilitate emergency and unplanned outings.

**b) Available Staff:**

At present there is no provision for a staff member to be used as a driver for public transport. The porters on-site have a busy internal and external timetable and have continuous duties across the site. Security staff allow access and egress to the site at specific times and the shift pattern is based around this routine.
An assessment of other disciplines identifies that there are no available human resources that could be allocated to transportation of visitors.

**c) Carer Need:**

The PCIT work closely with the carers to ensure that there are no issues with visiting the hospital. The PCIT have options available to ensure carers can get access to visits and also link in with Social Work colleagues if any specific needs are highlighted with carers visiting the hospital. If there are issues, then options are available and there is a budget that allows for taxi use if this is considered necessary.
There is one family that is supported to travel via taxi. Of the 53 carers that have submitted expenses this financial year there are five that use public transport – three utilise train & bus and two use the ferry as well as their car. The rest travel by car. There are no reported issues with carers struggling to attend.

## 3. ASSESSMENT

On reviewing all of the above, if the hospital were to try to provide a transport mechanism it will come at a cost, through staffing and the need to purchase or lease a vehicle. On looking at the current situation along with the PCIT, it does not appear to be an ongoing issue due to the close communication with the PCIT and the individual circumstances of visitors' attendance being pre-planned and known to the team.

There will of course be exceptional circumstances that arise as patient or carer needs change.

It is suggested that we retain the status quo and allow PCIT to highlight any changes that may require further review and assistance.

## 4. RECOMMENDATION

The Board is invited to agree with the assessment and to continue with current practice.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy /ADP** | This supports the carers strategy and assess current need of our carers and patients |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **1. Better Care**<br>m) be accessible to patients, their family and visitors ensuring their views and experiences are reflected in service improvements, implementing the Carer Strategy 2025/28. |
| **Workforce Implications** | Possibility of increased staff requirement |
| **Financial Implications** | If not approved there will be a cost to the hospital |
| **Route to Board**<br>Which groups were involved in contributing to the paper and recommendations. | Via CMT |
| **Risk Assessment**<br>(Outline any significant risks and associated mitigation) | Financial and Workforce Risks |
| **Assessment of Impact on Stakeholder Experience** | Minimal |
| **Equality Impact Assessment** | N/A |
| **Fairer Scotland Duty**<br>(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<br>√ There are no privacy implications.<br>□ There are privacy implications, but full DPIA not needed<br>□ There are privacy implications, full DPIA included |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 15 |
| Sponsoring Director: | Director of Nursing |
| Author(s): | Associate Director of Nursing |
| Title of Report: | Health and Care (Staffing) (Scotland) Act – Annual Report |
| Purpose of Report: | For Decision |

## 1 SITUATION

This report is intended to provide the Board with an update on the work undertaken at The State Hospital to ensure progress towards compliance with the requirements of the Health and Care (Staffing) (Scotland) (2019) Act.

Over 2024/2025 the hospital has continued to submit quarterly update reports to Health Improvement Scotland (HIS) outlining progress towards compliance with the Act. Communication takes place between HIS, the Director of Nursing and the Lead Nurse for Workforce Planning have taken place.

The requirement is to submit progress updates to HIS on an annual basis; the first annual report being due April 2025 (See Appendix One for TSH report). There is not an expectation that Boards are able to demonstrate “Substantial Assurance” across every duty at this stage. Instead there must be demonstration of a clear plan to meet each of the outlined principles and duties.

## 2 BACKGROUND

The Health and Care (Staffing) (Scotland) Bill was passed by parliament on 2 May 2019 and received Royal Assent on 6 June 2019 before finally being enacted in April 2024.

The Act is intended to provide a statutory basis for the provision of appropriate staffing in health and social care 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. This is defined in section **121A: Duty to ensure appropriate staffing.** The Act does not apply to non-clinical staff.

Further duties included in the legislations are:

- 121B Duty to ensure appropriate staffing: Agency worker
- 12IC Duty to have real-time staffing assessment in place
- 12ID Duty to have risk escalation process in place
- 12IE Duty to have arrangements to address severe and recurrent risks

- 12IF Duty to seek clinical advice on staffing
- 12IH Duty to ensure adequate time given to clinical leaders
- 12II Duty to ensure appropriate staffing: training of staff
- 12IJ Duty to follow the common staffing method
- 12IL Training and consultation of staff

Section 2 of the Act **Guiding principles etc. in health and care staffing and planning** suggests that Boards must also have regard to guiding principles when securing the provision of Health Care from a Third Party.

In order to ensure progress towards, and compliance with, The Health and Care (Staffing) (Scotland) Act 2019 the Scottish Government Red, Amber, Yellow and Green (RAG) rating has been adhered to.

| | |
|---|---|
| Green (Substantial Assurance) | Systems and processes are in place for, and used by, all NHS functions and all |
| Yellow (Reasonable Assurance) | Systems and processes are in place for, and used by, 50% or above of NHS |
| Amber (Limited Assurance) | Systems and processes are in place for, and used by, under 50% of all NHS |
| Red (No assurance) | No systems are in place for any NHS functions or professional groups |

## 3 ASSESSMENT

The table below provides the RAG rating for all groups of staff who work at The State Hospital and are covered by the legislation, as at 30th March 2025. These are self-assessment ratings:

| All Professional Groups | | |
|---|---|---|
| Duty | Duty Title | RAG |
| 121A | Duty to ensure appropriate staffing. | Substantial Assurance |
| 121B | Duty to ensure appropriate staffing: Agency worker | N/A |
| 121C | Duty to have real-time staffing assessment in place | Substantial Assurance |
| 121D | Duty to have risk escalation process in place | Substantial Assurance |
| 121E | Duty to have arrangements to address severe and recurrent ri | Substantial Assurance |
| 121F | Duty to seek clinical advice on staffing | Substantial Assurance |
| 121H | Duty to ensure adequate time given to clinical leaders | Substantial Assurance |
| 121I | Duty to ensure appropriate staffing: training of staff | Substantial Assurance |
| 121J | Duty to follow the common staffing method | Substantial Assurance |
| 121L | Training and consultation of staff | Reasonable Assurance |
| N/A | Planning and Securing Services | Substantial Assurance |

The hospital has made significant progress in working towards demonstrating compliance with each of the duties outlined above and over the last year have progressed from demonstrating “substantial” assurance in five out of the ten duties to nine out of the ten duties. The four areas that have progressed over 2024/2025 were 121C, 121F and 121H and 121J.

Our Lead Nurse for Workforce Planning continues to work alongside colleagues from Health Improvement Scotland (HIS) to progress assurances in the remaining duty which is currently self-rated as “Reasonable” assurance with compliance. Staff training needs have been identified and included within the Corporate Training Plan for 2025/2026.

The hospital currently has a number of systems and processes in place to assess, monitor and

respond to changes in real-time staffing. Following the introduction of the Health and Care (Staffing) (Scotland) Act 2019 engagement work with Health Improvement Scotland has been ongoing to develop and test a revised workload tool that is fit for purpose within forensic healthcare environments. The absence of a suitable tool has been acknowledged and implementation of the revised tool is on track for October 2025. As part of this implementation work is now also underway to fully embed the use of the Optima electronic roster system across all areas of the hospital and to move away from multiple layers of recording staffing levels. As part of this work changes will also be explored to improve functionality of the Optima system to align with hospital's protocols and the Health and Care Staffing legislation. Likewise, work to explore resolving national challenges around the Medical Professional use of SafeCare have now started with external agencies (i.e. RL Datix and HIS) and will continue ongoing.

As noted earlier, the hospital has continued to submit Quarterly update reports to Health Improvement Scotland outlining progress towards compliance with the Health and Care (Staffing) (Scotland) Act 2019, and regular Board calls attended by the Director of Nursing and the Lead Nurse for Workforce Planning have provided positive feedback.

## 4 RECOMMENDATION

The Board is invited to note the positive progress towards ensuring compliance with the Health and Care (Staffing) (Scotland) Act 2019 and approve the first annual update report for submission to Health Improvement Scotland.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy /ADP** | Supports delivery against the Workforce strategy/ ADP and compliance with the HCSA. |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **4. Better Workforce**<br>c) Deliver and monitor staff resourcing aligning to the Health and Care (Staffing) (Scotland) Bill (2019) across the State Hospital, and in conjunction with the local delivery of the national e-rostering programme, through the Workforce Governance Group |
| **Workforce Implications** | Noted in the paper |
| **Financial Implications** | No additional finance implications at this point. |
| **Route to Board**<br>Which groups were involved in contributing to the paper and recommendations. | Clinical Governance and Staff Governance |
| **Risk Assessment**<br>(Outline any significant risks and associated mitigation) | Failure to adhere to Health and Care Staffing Act requirements would mean TSH is non-compliant with legislation. Progress towards compliance is monitored through internal Governance structures and Board calls with HIS. |
| **Assessment of Impact on Stakeholder Experience** | Staff engagement around Health and Care Staffing requirements ongoing |
| **Equality Impact Assessment** | Not required |
| **Fairer Scotland Duty**<br>(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<br>√ There are no privacy implications.<br>□ There are privacy implications, but full DPIA not needed<br>□ There are privacy implications, full DPIA included |

| | |
|---|---|
| **Name of organisation:** | The State Hospital |
| **Report authorised by:** | *Karen McCaffrey*<br>*Director of Nursing and Operations*<br>*Date 16/04/2025* |
| **Location where report is published:** | |

**Health and Care (Staffing) (Scotland) Act 2019 Annual Report**

1 Section 12IM of the National Health Service (Scotland) Act 1978 ("the 1978 Act") as inserted by section 4 of the Health and Care (Staffing) (Scotland) Act 2019 ("the 2019 Act") requires all Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board for Scotland and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), to publish, and submit to Scottish Ministers, an annual report setting out how they have carried out their duties under sections 12IA (including how the relevant organisation has had regard to the guiding principles in section 2 of the Act), 12IC, 12D, 12E, 12F, 12IH, 12II, 12IJ and 12IL of the 1978 Act (all inserted by section 4 of the 2019 Act).

2 Section 2(1) of the 2019 Act requires Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board for Scotland and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), when carrying out the section 12IA duty to ensure appropriate staffing, to have regard to the guiding principles for health and care staffing in section 1 of the Act. Section 2(3) of the 2019 Act requires relevant organisations to provide information to the Scottish Ministers on an annual basis on the steps they have taken to comply with this requirement. Section 2(4) of the 2019 Act reqiures this information to include how these steps have improved outcomes for service users.

3 Section 2(2) of the 2019 Act requires Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board for Scotland and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), when planning or securing the provision of health care from a third party under the 1978 Act to consider both the guiding principles for health and care staffing in section 1 of the Act and the need for the third party to have appropriate staffing arrangements in place. Section 2(3) of the Act requires relevant organisations to provide information to the Scottish Ministers on an annual basis on the steps they have taken to comply with this requirement. Section 2(4) of the 2019 Act requires this information to include how these steps have improved outcomes for service users.

4 Reporting for section 12IB (duty to ensure appropriate staffing: agency workers) is within a separate quarterly report and not included in this template.

5 Guidance on completing the template can be found below. Completed reports must be returned to hcsa@gov.scot by 30 April 2025. If you require further assistance or have any queries, please contact hcsa@gov.scot.

**Report approval**

6 This tab should be completed by the person signing off the report. An electronic signature is acceptable.

7 The Act requires the annual reports to be published by relevant organisations. Please enter a hyperlink to the webpage where the report can be found.

**Summary**

8 This tab asks for an overall summary of how the relevant organisation has carried out all of the duties and requirements of the Act. This should include all NHS functions provided by all professional disciplines covered under the Act (see https://www.gov.scot/publications/health-and-care-staffing-scotland-act-2019-overview/pages/roles-in-scope-of-the-act/ for more details of which staff groups are covered under the Act).

9 Following receipt of the reports from relevant organisations, the Scottish Ministers must collate these and lay a combined report before Parliament, along with an accompanying statement setting out how the information will be taken into account in policies for staffing of the health service. To enable this process, the information provided by relevant organisations must be comprehensive and pertinent to the staffing of the health service. Please complete these questions in detail, setting out the key achievements, outcomes, learning and risks and how this information has been used to inform workforce planning at the local level.

10 The tab then asks for an overall level of assurance of the relevant organisation's compliance with the Act, using the assurance categories as detailed below.

**Individual duties / requirements**

11 The next tabs look at specific elements within each of the individual duties / requirements of the Act, asking relevant organisations to provide an assessment of compliance against each statement, using the RAG classification below. Again, this should include all NHS functions, provided by all professional disciplines covered under the Act, with the exception of 12IJ and 12IL which only apply to certain types of health care, in certain locations using certain employees (more information is provided in these tabs). Next to the column for the RAG status is a column entitled 'Comment'. In this column, relevant organisations should provide detail to explain the RAG status, detailing evidence of compliance where appropriate, or gaps and areas of ongoing focus. For example, details of the organisational structures, systems and / or processes being used, such as SafeCare or SOPs in place. If the RAG status is not green then explanation should be provided advising of any gaps or areas of ongoing work, and of the NHS functions and / or professional groups that do not have systems and processes in place / are not using them.

12 Next, the relevant organisation is asked to provide details of areas of success, achievement and learning associated with the particular duty or requirement, along with indicating how this could be used in the future (for example, could learning in one area be applied to other areas). Again, in order to provide meaningful information that can inform health care staffing policy, relevant organisations are asked to complete this in some detail.

13 The relevant organisation is then asked to provide details of any areas of risk where they have been unable to achieve or maintain compliance with the particular duty or requirement, or where they have faced any challenges or risks in carrying out their duties or requirements. In this section, relevant organisations are also asked what actions have been or are being taken to address this - to show the 'pathway to green'. Again, in order to provide meaningful information that can inform health care staffing policy, relevant organisations are asked to complete this in some detail.

14 Finally, relevant organisations are asked to provide a declaration of the level of assurance they have regarding compliance with the specific section of the 1978 / 2019 Act, using the classification as below.

15 Two tabs, section 12IA and 'planning and securing services' ask additional questions to enable appropriate feedback to evidence compliance with these duties or requirements. Similar to above, these should be answered in su

**RAG status**

16 When asked to provide a RAG status, please use this key.

| | | |
|---|---|---|
| Green | | Systems and processes are in place for, and used by, all NHS functions and all professional groups |
| Yellow | | Systems and processes are in place for, and used by, 50% or above of NHS functions and professional groups, but not all of them |
| Amber | | Systems and processes are in place for, and used by, under 50% of all NHS functions and professional groups |
| Red | | No systems are in place for any NHS functions or professional groups |

17 **Declaration and level of assurance**

When asked to provide declaration of the level of assurance, please use this key.

| Level of assurance | | System adequacy | Controls |
|---|---|---|---|
| Substantial assurance | | A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited. | Controls are applied continuously or with only minor lapses. |
| Reasonable assurance |  | There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited. | Controls are applied frequently but with evidence of non- compliance. |
| Limited assurance | | Significant gaps, weaknesses or non- compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited. | Controls are applied but with some significant lapses. |
| No assurance | | Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited. | Significant breakdown in the application of controls. |

## Guidance for using this exemplar

This exemplar has been developed to provide an example of the type and level of information required within the Board's Annual report.

The exemplar has used feedback received in the previous quarterly reporting prior to commencement, and offers examples of where there is full compliance, and where there is work ongoing to achieve compliance. The content aims to address areas of ongoing concern or clarity highlighted at the individual Board feedback sessions.

It is for the Board to determine the content and detail provided, recognising that the Board must publish their Annual Report, as well as submit to Scottish Ministers. The exemplar will provide guidance and support to staff completing the return on behalf of the Board.

The Scottish Government recognise that this is the first annual report, reflecting the first year working within this new legislative framework. There will be learning for all organisations, and that work will be ongoing to strengthen and embed the necessary structures required to meet all aspects of the different duties and requirements of the Act, for all staff within scope. Demonstrating a good understanding of your system, the areas of strength, and area of ongoing focus and action will help provide information to Scottish Ministers about how the Act is ensuring appropriate staffing is in place (both in real-time staffing and through workforce planning) to enable high quality, safe services and improved outcomes for patients and staff wellbeing.

In general, information provided should not be by professions or areas, but an overview of the whole board position.

Examples of good practice and where boards are facing challenges will be appreciated to demonstrate to impact of the Act and support future meaningful policy

**Summary report**

Please answer the questions below, to provide an overall assessment of how the organisation has carried out its duties under section 2 of the 2019 Act, and sections 12IA, 12IC, 12ID, 12IE, 12IF, 12IH, 12II, 12IJ and 12IL of the 1978 Act (inserted by section 4 of the 2019 Act).

**1 Please advise how the information provided in this report has been used or will be used to inform workforce plans.**

To build on the development of the self assessment and to monitor it's progress.

To ensure our work plan ties in with the duties of the act identifying areas of good practice as well as areas of learning.

The level of assurance attached to each duty will provide us with a focus to prioritise our work plan.

Provides a resource for engagement with staff especially out with Nursing.

**2 Please summarise any key achievements and outcomes as a consequence of carrying out the duties and requirements in the Act.**

Staff engagement and awareness sessions have delivered across disciplines,

Robust data analysis of funded and in post establishment identified gaps in workforce in line with current clinical acuity.
Board approval to over recruit additional healthcare support workers.

Robust systems and processes currently in place to manage rostering along with real time escalation of risk and mitigations taken.

Data collection and reporting of trends, training and awareness factored into resourcing decisions.

**3 Please summarise any key learning and risks identified as a consequence of carrying out the duties and requirements in the Act.**

As outlined in section 121C the main issues encountered have been in relation to fully implementing the eRostering platform which does not link to SSTS or Eess.

**4 Please indicate the overall level of assurance of the organisation's compliance with the Act, reflecting the report submitted.**

Substantial Assurance

**1 Guiding principles for health and care staffing**
**2 Guiding principles etc. in health and care staffing and planning**
**12IA Duty to ensure appropriate staffing**

Guidance chapter link

**RAG status**

| Section | Item | Status | Comment |
|---|---|---|---|
| 12IA(1) | Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary (see guidance for details of professional disciplines included within the Act) are working in such numbers as are appropriate for the health, wellbeing and safety of patients; the provision of safe and high-quality health care; and in so far as it affects either of those matters, the wellbeing of staff. | Green | To ensure appropriate staffing levels TSH have systems and processes in place. These include, but is not limited to, our multidisciplinary daily resource huddles, twice weekly resource planning meetings, and escalation routes to ensure the requirements of the duty (121A) are met. In addition to the previously reported Nursing progress in the Q3 report to HIS we now include evidence from those other disciplines named under the Act: AHP, Psychology, Risk & Resilience, Pharmacy, Medical, and Learning and Development.<br><br>Operational systems and processes are in place for each multidiscipline. This varies according to the size and delivery of the department. Routine updates are reported to Workforce Governance Group and to the Board providing details of our assurance towards compliance. |
| 12IA(2)(a) | These systems and processes include having regard to the nature of the particular kind of health care provision | Green | Workforce planning is agreed for each financial year. A monthly workforce report is provided to consider areas of concern, recruitment progress, and vacancies.<br><br>Datix is available to all staff to escalate risk. LearnPro and in person mandatory training is available to all staff. Training compliance is reported within TSH to ensure full engagement and compliance.<br><br>Optima has been rolled out across the organisation and is being used to record day to day staffing activity. Additional benefits of Optima have stilled to be realised with the further roll out of SafeCare, eJob Plan, Bank, and Loop. The continued roll out of eRostering is monitored via the BAU Team which is Led by the Director of Workforce. Areas of concern are escalated as required to the Corporate Management Team then the Board.<br><br>Staffing requirements within the Nursing Directorate are agreed and determined by level of risk and by the clinical model delivery plan – taking into account skill and gender mix. Nursing staffing levels can vary in line with clinical acuity (increased with the need for higher nursing input) and regularly reviewed via the weekly clinical team meetings and RMO reviews. The MHLD workload tool expert working group have developed an abridged version of the current tool which was tested out across two wards to ensure this was fit for purpose in a high secure setting. A complete two week tool run has been carried out across all ten wards. In the absence of SafeCare, real time reporting on resourcing is collated via twice daily robust resource huddles. |
| 12IA(2)(b) | These systems and processes include having regard to the local context in which it is being provided | Green | Daily resource huddles are attended by heads of service. Before the dayshift and backshifts, the local context of each area's staffing levels are fully discussed and decisions are made to allow dynamic adaptations via Multidisciplinary Team collaboration as necessary. |
| 12IA(2)(c) | These systems and processes include having regard to the number of patients being provided it | Yellow | Whilst awaiting the roll out of SafeCare and the implementation of the new MHLD Workload Tool which will be named in legislation in October 2025, TSH ward based resourcing is reviewed on a dynamic basis via daily resource huddles and the role of Senior Clinical Cover. With regard to consideration of patient numbers, as we provide clinical care within a high secure setting a minimum of 3 staff are required when patients are out with their rooms and a further member of staff is required to be able to respond to incidents across all wards irrespective of patient numbers. |

| | | | |
|---|---|---|---|
| 12IA(2)(d) | These systems and processes include having regard to the needs of patients being provided it | Green | Staff feedback is collated via Daily Huddles, iMatter, weekly Business meetings, and Staff Survey's with direct feedback coming for service leads and Staff Bulletins.<br><br>The Person Centre Improvement (PCIT) collate carer and patient feedback including via What Matters to You. This enables us to look at changes to activity or service redesign. We have an established Patient Partnership Forum and outcomes from this group are fed into the wider governance meetings. Ward based sub streams of this group include a patient representative at each stream. MWC visits provide routine feedback on the patient /staff experience. These visits celebrate areas of success and areas for improvement. |
| 12IA(2)(e) | These systems and processes include having regard to appropriate clinical advice | Green | All processes and systems include appropriate clinical advice from service leads. Out of hours the role of Senior Clinical Cover provides onsite senior clinical advice. This is supported by the On Call Consultant and Junior Doctor. |
| 2(1) | These systems and processes include having regard to the guiding principles when carrying out the duty imposed by section 12IA | Green | All processes and systems take into consideration staff & patient wellbeing, mitigation of risk, and governance processes. The Risk Management Team review all datix records which are RAG rated. These are recorded and reported at the Health and Safety Committee. Learning opportunities and trends are reviewed with staff engagement so that improvements can be monitored feedback is given directly to those who escalated the risk. |
| | There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met) | Yellow | An action plan is being developed to support all disciplines achieve compliance with the duty. Significant progress has been made towards compliance within nursing. Development sessions are tabled to advance progress within Medical, Psychology, and AHP |

**Please provide information on the steps taken to comply with section 12IA.**
These are steps taken to comply with 12IA in general. Examples could include information about workforce planning, national and international recruitment, retention, retire and return, service redesign, innovation, staff wellbeing, policies around supplementary staffing.

36 hour working week: We have achieved the first reduction of 37hrs within year 2024/25 and work continues to reach the 36hrs working week by April 2026.
eRostering Roll Out: All areas are now using Optima on a day to day basis. Plans are in place to introduce a Business as Usual model which will replace the dedicated project teams secondment. Further roll out, including SafeCare, Loop, eJob Planning, the 36 hour week and what challenges these bring will be determined based on how the Business as Usual model develops. Double Keying remains a challenge with SSTS and eEES.

Daily resource huddle changes: The Hub Coordinators (nominated hub Charge Nurses) attend the daily huddle, which has enabled positive development of charge nurses. We have observed evidence of problem-solving staffing issues by demonstrating flexibility within a hub to minimise the impact directly to patient care.
Daily huddles continue to have Medic attendance to ensure they understand the impact clinical decisions may have on nursing resource.

Workforce Planning: A well established Workforce Governance Group monitors and reports on all professions workforce performance. Vacancies and recruitment are closely monitored. A significant range and volume of activity aimed at mitigating ongoing challenges includes:
• Rolling recruitment drives to address specific vacancy challenges per Service;
• Positive traction on Agenda for Change job description reviews to aid recruitment
• Increasing access to nursing training on an “earn as you learn” basis to “grow our own;”
• Consideration of Modern Apprenticeships in non-clinical areas;
• Workforce Governance Group reviewing succession planning;
• Retire and return is widely used for all professional groups across the Board. Partial retirement is now a further option to retain skilled members of staff;
• Exit questionnaire data is extremely important to the Board in terms of understanding why staff choose to leave our employment, and what can be done to improve the overall staff experience and increase retention rates.

Heads of service Input in relation to HCSA:
• AHP and Psychology are members of national groups and linking into national advancements to develop RSTS. Linking in with HIS to ensure compliance.
• Pharmacy (on an SLA at TSH) have specific resource plans in place to ensure delivery of service. If this is not achievable, resilience planning is in place to draw pharmacy input from NHS Lothian.

**Please provide information on how these systems and processes, and their application, have improved outcomes for service users**

This should include - but not be limited to - data in relation to patient safety and quality of care measures and outcomes, patient feedback and adverse event reporting; what this data has shown and any trends; and any actions taken as a result.

Monthly Workforce Report – allows hospital oversight of funded establishment v in post WTE, oversight of TSH vacancies, oversight of recruitment onboarding, highlights challenges in specific departments.

Daily resource huddle changes: The Hub Coordinators (nominated hub Charge Nurses) attend the daily huddle, which has enabled positive development of charge nurses. We have observed evidence of problem-solving staffing issues by demonstrating flexibility within a hub to minimise the impact directly to patient care.

Daily huddles continue to have Medic attendance to ensure they understand the impact clinical decisions may have on nursing resource.

Feedback from our new start nursing staff alerted the organisation to frequent cover required across wards, this is being addressed and no new start will move from their base ward within the first six weeks. With the increase of workforce data collection we are now able to challenge practice with evidence particularly in areas of daytime confinement and the scheduling of outings both Clinical and pre transfer. The development of tableau has provided clinical leaders with live data around attendance management, special leave and planned leave in accordance to the P.A.A.

eRostering Roll Out: All areas are now using Optima on a day to day basis. Plans are in place to introduce a Business and Usual model which will replace the dedicated project teams secondment. Further rollout, including SafeCare, Loop, eJob Planning, the 36 hour week and what challenges these bring will be determined based on how the Business as Usual model develops. Double Keying remains a challenge with SSTS and eEES.

**Areas of success, achievement or learning**
Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

| Area of success / achievement / learning | Details | Further action |
|---|---|---|
| This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. | This should describe the situation: what is the success, achievement or learning? For example, application of eRostering has allowed senior personnel to be able to see staffing in real-time across all areas, allowing staff to be reallocated as required to reduce level of risk. | This should describe how the success, achievement or learning could be used in the future. For example, continue the roll out of eRostering across the organisation, using learning from areas that have already implemented. |
| The Human Resource Team provide expertise and support staff in areas of workforce | Recruitment and Retention<br>Work overseen by the relevant professional and workforce programmes, is ongoing.<br>Efforts are impacted by challenges in workforce supply and the continued existence of | To ensure future attendance at recruitment fayres and online events.<br><br>Continue to evolve Social Media Communication Strategy promoting TSH as a positive place to work. |

| | | |
|---|---|---|
| including to and adhering to Once for Scotland and local policies and procedures | vacancy gaps across a range of professions. However a range of concerted improvement activities aimed at mitigating ongoing challenges are underway. These include:<br>• Rolling recruitment drives to address specific vacancy challenges per Department;<br>• Positive traction on Agenda for Change job description reviews to aid recruitment<br>• Increasing access to nursing training on an “earn as you learn” basis to “grow our own;”<br>• Consideration of Modern Apprenticeships in non-clinical areas;<br>• Workforce Governance Group reviewing succession planning;<br>• Retire and return is widely used for all professional groups across the Board. Partial retirement is now a further option to retain skilled members of staff;<br>• Exit questionnaire data is extremely important to the Board in terms of understanding why staff choose to leave our employment, and what can be done to improve the overall staff experience and increase retention rates<br><br>The State Hospital developed a Recruitment and Retention Strategy that was aligned with the three-year workforce plan 2023-2025. The strategy recognised that a robust and efficient recruitment process significantly contributed to the delivery of our services. Equally, the State Hospital remained committed to retaining staff, recognising the resource required to recruit and induct new employees, as well as the skills, knowledge, and support that experienced staff brought to the organisation. The primary goal was to ensure we recruit the right people, in the right roles, at the right time.<br><br>The strategy focusses on 5 key areas:<br>• Visibility – Build the State Hospital brand across professions and communities.<br>• Systems – Use data to influence future decisions and upgrade current processes.<br>• Workforce Planning – Review workforce needs to ensure we have the right staff in posts.<br>• Recruitment Skills – Develop manager skills and enhancing current staff skills.<br>• Retention – Monitor staff satisfaction and turnover and act on issues.<br><br>Visibility<br>• As part of our strategy to enhance the State Hospital brand across various professions and communities, we recognised several effective methods to achieve this goal, one of which was increasing our presence on social media platforms. With support from our communications team, all vacancies are now advertised on social media using a standard advert template. Additionally, the communications team developed employee profile posts. These profiles feature volunteers who share information about themselves, including their role at the State Hospital, their tenure, and why they enjoy working here. The State Hospital Facebook page has grown to 1.7k followers with posts reaching up to 8.2k people. Facebook is now the State Hospital’s third largest applicant source after NHS Scotland Careers Website and Indeed.<br>• The State Hospital committed to increasing attendance at community events. We have established a team of employability ambassadors who support events at educational institutions and career fairs. Participating in these events helps enhance our brand visibility and reputation within the community and industry. It has allowed the organisation to showcase what it is like to work in a high secure setting, discuss career opportunities, and provide education on the type of roles available and the benefits for employee, thereby attracting both potential job seekers and future employees. During 2024 we attended ten educational institutes and held two talks via Microsoft teams.<br>• As part of our efforts to enhance visibility, the recruitment section of the State Hospital website was reviewed to provide potential applicants with more comprehensive information about working at the State Hospital. The main page of the website now includes a link to any current vacancies within the organisation, allowing for easy access for potential applicants. As the communications department continues to develop its services, we hope to add video blogs in the future.<br>Systems<br>Throughout the strategy period, significant efforts have been made to align the organisation's recruitment processes with national requirements. The eApproval function on Jobtrain, which went live in late 2022, has been successfully integrated | Produce a presentation that can be delivered within schools, colleges and universities<br><br>Gather feedback on the new corporate inductions<br><br>Survey feedback collated and reported in an action plan.<br><br>To monitor themes, escalating risks and taking actions from the exit interview process.<br><br>To ensure compliance with Once for Scotland policies for NHS.<br><br>Focusing on the individual nature of a situation by taking a person-centred approach<br><br>Face to face training sessions and a detailed special bulletin |

into the organisation, with all job approvals now conducted through this system. The State Hospital remains one of the few boards to have adopted this function. The adoption of the Yellowfin system, has streamlined the recruitment process and significantly improved overall efficiency. The system also communicates national recruitment KPIs, which are presented in the monthly Workforce Report.

Workforce Planning
Workforce planning is crucial for NHS Scotland and the State Hospital to ensure that the right people with the right skills are in the right place at the right time to deliver high-quality care. Effective workforce planning helps address the changing needs of the population, manage workforce demographics, and ensure sustainable staffing levels.

• Young People
To ensure young people are provided with employment opportunities at the State Hospital, an organisational position was agreed upon based on a risk assessment. We will welcome applications from individuals under the age of 18 for non-clinical roles. However, to be eligible for clinical roles, applicants must be 18 years or older. A comprehensive guide was also produced to support managers in recruiting young people. This guide includes information on employing young people, employment law considerations, a risk assessment checklist, risk assessment guidance, and a risk assessment template. Work continues on increasing the number of young people within our organisation.

• Apprenticeships
The organisation has relaunched its Modern Apprenticeship Guidance and is committed to increasing the uptake of apprenticeships. The guidance aims to support managers locally in bringing apprentices into the organisation. Further work is currently underway on how the organisation supports foundation apprenticeships, in collaboration with South Lanarkshire Council. These apprenticeships provide valuable opportunities for young people to gain hands-on experience and develop their skills in various fields, such as administration, facilities, and clinical roles. By supporting apprenticeships, we not only help young people kick-start their careers but also ensure a pipeline of skilled talent for the organisation. This initiative is part of our broader strategy to invest in the future workforce and address the ageing demographics within the organisation.

• Work Placements and Demonstrator Programme
Maximizing opportunities for accessing employment at the State Hospital required careful thought due to the organisation's unique nature. The State Hospital has frequently been asked to support work experience requests from students and other interested parties seeking to learn more about forensic mental health or gain experience in specific areas such as administration or human resources.  To support managers with these requests and in order to maximize opportunities for people to access employment with our organisation, Work Placement guidance was developed. Work placements can range from brief ‘tasters’ lasting half a day to programs extending over one or two weeks, or even several months. Some work placements offer hands-on experience, while others provide insights, observation, and work shadowing. All can provide valuable experiences for individuals looking to pursue a career in the health sector and offer significant benefits to the organisation in terms of reputation, visibility, and social responsibility. Through national employability work, an opportunity arose with our neighbouring health board, NHS Lanarkshire, in developing the Demonstrator Programme between the two NHS boards within the Lanarkshire

region. In collaboration with NHS Lanarkshire and South Lanarkshire Council the State Hospital agreed to host two Demonstrator opportunities. The Demonstrator Programme focuses on supporting parents aged 18 and over to re-enter the workforce or upskill within the NHS. This initiative aligns with the Scottish Government's No-One Left Behind agenda, targeting child poverty and reinforcing our commitment as an local employer and Anchor Organisation. The programme is designed with flexibility in mind, accommodating participants' childcare needs and new routines. With support from the Workforce team and South Lanarkshire Councils Key Worker, participants are provided with wraparound support in order for participants to build confidence, wellbeing and personal development with the goal of achieving permanent employment.

• Supplementary Staffing Register
The Supplementary Staffing Register for Nursing remains an essential tool for addressing staffing gaps within our service. It is a particularly valuable resource for those planning to retire and subsequently return to work in a more flexible capacity. There is significant potential for further development of this register within the organisation. Continued efforts from the nursing directorate are required to review and enhance the existing framework. By expanding this initiative, we can provide more opportunities for staff considering leaving the organisation to remain involved. Additionally, extending this resource to student nurses would be highly beneficial, offering them practical experience and easing the transition into professional roles. To maximize the register's impact, a strategic review and targeted enhancements by the nursing directorate will be crucial.

• Succession Planning
Alongside our strategic work, there was an initiative to develop a good practice approach to succession planning. There has always been a need to develop our staff, but in the past, succession planning often occurred in an ad hoc or unmanaged manner. In recent years, the changing workforce demographics within the Nursing and AHP community have highlighted the need for more structured thinking regarding succession planning. This has posed challenges for the recruitment and retention of skilled staff, leading to delays in appointing key roles or diluting service quality and provision. To address this, we developed succession planning guidance for managers to understand their roles in this process. This guidance includes information such as guiding principles, tools for supporting succession planning, personal development plans, and other key aspects.

Recruitment Skills
A training presentation for new hiring managers was developed. This training encompasses a wide range of topics, including legislation, best practices for advertising, shortlisting, interviewing, and onboarding. Moreover, the program addresses legal issues in recruitment such as unconscious bias, equality, diversity, and inclusion, as well as reasonable adjustments within the workplace. This approach ensures that hiring managers are well-equipped to create a fair and inclusive recruitment process. This training is available to anyone involved in the recruitment and selection process to ensure compliance with workforce policies. By equipping our hiring managers with this knowledge, we aim to foster a more inclusive and equitable work environment, ultimately enhancing the overall quality of our hiring practices.

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| Nursing Directorate has the responsibility to oversee staff well being and attendance at work as well as ensuring we delivery a high quality of clinical care to our patients. | Effective real time staffing assessments-<br>The State Hospital has robust oversight and monitoring processes currently in place to determine real time staffing on a daily basis.<br><br>This process involves daily resource huddles which are attended by heads of department. Before the AM/PM shifts, the local context of each area's staffing levels are fully discussed and decisions are made to allow dynamic adaptations via Multi-Disciplinary Team collaboration.<br><br>Overarching staff model<br>Despite the overtime pressures, the forecast for the year remains for a breakeven position to be achieved, with a savings target on track. To better understand the contributory factors to overtime spend within the Nursing Directorate a deep dive into the following areas was undertaken:<br>• Review of Clinical Acuity<br>• Review of the Nursing Predicted Absence Allowance (PAA)<br>• Review of resourcing use within the new Clinical Model<br>• Review of attempts to eradicate daytime confinement<br>• Review of requirements needed to reduce reliance on overtime<br><br>One outcome from this data indicated that an average of seven additional nurses were required per day to provide safe levels of care. A full presentation seeking recruitment of an additional 10wte above the current funded establishment was delivered to the Corporate Management Team in December 2024 and received approval thereafter. We have successfully recruited 9.4wte Band 3 nurses who start in March 2025.<br><br>Management Redesign – Nurse Directorate<br>A couple of senior posts within the Nursing Directorate became vacant, which provided an opportunity to revise the portfolios and consider whether we required to use the funding from these posts in a different way. There was an identified need to strengthen the operational management within the directorate, as well as free up lead nurses to increase the focus on supporting the professional and clinical aspects of practice. Therefore, we aim to introduce two service manager posts to the directorate and they will assume line management responsibility for the SCNs and responsible and accountable for the operational service delivery. Recruitment of these posts is planned for early in the new financial year.<br><br>Effective roster management – Nursing<br>Following a Quality Improvement piece of work to support improved rostering practices, All SCN's and CN's were provided with training and support using an agreed Standing Operating Procedure. This was to ensure a consistent approach was used to create the 6 weekly rosters. We are now seeing the benefit of this investment with an improvement of skill mix and gender balance at the roster creation stage particularly on night shift. Work will continue to progress and improve with the implementation of the reduced working week.<br><br>Reduced Working Week – Nursing<br>The State Hospital requires to comply with the nationally agreed pay award to reduce the whole time equivalent working week to 36 hours by April 2026. A short life working group has been establishment to engage with the nursing workforce through face to face sessions and/or via a questionnaire. This engagement will enable us to review our current shift systems and explore opportunities for a single approach to eRostering taking into account flexible working and or flexibility within the shift system, improved wellbeing and more efficiency in the management of the rosters. This will provide additional opportunities to develop a consistent rostering arrangement for all staff and maximise the potential from Health Optima when creating rosters. The engagement sessions are planned to commence in March 2025 for 4 weeks | To continue to develop collaborative working amongst the multidisciplinary team, ensuring good working relationships<br><br>Provide a forum for sharing areas of concern and risk escalation and what actions have been taken<br><br>Improve communication channels across the nursing directorate.<br><br>Agreed over recruitment of Band 3 Nursing Assistants as part of a test of change, in post April 2025.<br><br>Secure Job Descriptions and progress to advert and interview for Redesigned Structure<br><br>Pilot to be rolled out in Mull Hub to test out decentralised resourcing to hub management.<br><br>SLWG established to support progress towards RWW in line with national requirements |

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| | engagement sessions are planned to commence in March 2026 for 4 weeks.<br><br>Delivery of Overtime via Optima<br>Our Clinical Admin Department are now managing and delivering overtime via the Optima system to the Clinical Admin – Hub Receptionist roster. This development allows real time staffing in an area that must have staff in place to allow patient movement. To deliver this feature, the necessary engagement instructions and guidance have been developed to allow staff to enter their availability into LOOP and for the manager to be able to search this availability, thereafter assigning and notifying staff of overtime allocation. Following the successful test of this within Clinical Admin we have plans to introduce this function in one of the nursing hubs - Transitions Service in Q4. | |
| Medical: The Medical Director has overall accountable for the governance of the Medical Department in the Hospital. Day to day operational management of the Department is through the Associate Medical Director, supported by the PA to the MD/AMD. | Medical eJob Planning<br>• All substantive Medical Staff have a yearly Job Planning Meeting with the Associate Medical Director (or Medical Director in the case of the AMD). Regular reviews of the efficient and effective use of consultants' time are critical during a period of rapid change in both medical technology and healthcare delivery systems.<br>• Systems and processes are in place to ensure that robust medical coverage is in place. This includes out of hours via on call rotation and in the event of unplanned absence<br>• Medic engagement in daily resourcing huddles to understand the impact of clinical acuity and associated impact of decision making<br>• Introduction of systems and process in collaboration with pharmacy to ensure safe prescribing<br>• Implementation of clinical model has ensured a progressive pathway through TSH. This service delivery change includes medics chairing newly developed service leadership teams and reviewing the impact of the clinical model on safe staffing/patient care.<br>• Good outcome from NES visit and GMC survey re postgraduate training<br>• Job Planning now delivered via eRostering | Ongoing roll out of Optima Products |

**Areas of escalation, challenges or risks**

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain c

| Area of escalation / challenge / risk | Details | Action |
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| This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. | | |
| Financial Pressures | The State Hospital currently relies on overtime to fill any nursing staff deficits. As detailed above a piece of work was commissioned to reduce the reliance on overtime within the nursing department and as a result an additional 9.4WTE have been recruited to support safe staffing over the 2025-2026 financial period. Running in parallel to this recruitment is the noted risk of WTE loss through the Reduced Working Week (RWW). By April 2025 the hospital will have lost 8WTE hours to support the RWW. This is expected to rise to approximately 12WTE by March 2026.<br><br>In addition to noted risks associated with the RWW, over the coming months the hospital will prepare to open an additional ward to support female patients. Whilst initial funding has been secured and a recruitment strategy is underway there is the recognised risk in recruiting and retaining additional nursing staff required to support this new ward. | Monthly Finance meeting to monitor nursing spend with SCN's and Management Accounts |

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| Sickness | Sickness remains above 5% despite efforts to reduce this. Within the Nursing Department there are multiple strands of work focused on reducing absence rates. Improvement activities include monthly finance meetings with each Senior Charge Nurse and absence RAG rating meetings which are chaired and supported by the Head of Human Resources. | Monthly meetings  with Director of Nursing, Workforce and CEO. SCN's meet monthly with Head of HR. |
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**Declaration:** The relevant organisation has systems and processes in place to meet the requirements of this duty, and

**Level of Assurance:** Please indicate level of assurance provided

Substantial Assurance

**12IC Duty to have real-time staffing assessment in place**

**RAG status**

| Section | Item | Status | Comment |
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| 12IC(1) | Clearly defined systems and processes are in place, and utilised, for the real-time assessment of compliance with the duty to ensure appropriate staffing, in all NHS functions and professional groups. | Green | • Whilst awaiting the roll out of SafeCare and the implementation of the new MHLD workload tool, TSH ward based resourcing is reviewed on a dynamic basis via daily resource huddles and the role of Senior Clinical Cover. Discussions have been supported with HIS that our robust operational model currently in place provides reassurance that we are compliant with legislation until the roll out of SafeCare.<br>• No system is currently in place for AHP or Psychology however work is underway with the Workforce Lead, HIS, and other national groups to roll out the MDPJ Tool.<br>• Appropriate medical care is in place in line with patient numbers to ensure safe delivery of care via the appropriate number of medic sessions. Safecare is currently being explored in consultation with RL Datix and HIS. |
| 12IC(2)(a) | These systems and processes include the means for any member of staff to identify any risk caused by staffing levels to the health, well-being and safety of patients; the provision of safe and high-quality health care; or, in so far it affects either of those matters, the wellbeing of staff. | Green | All staff have the ability to raise a risk or concern through their Charge Nurse or Nurse in Charge, or twice daily resource huddles, and via handover discussions.<br><br>All staff have access to the Datix risk management system and can raise a Datix under the category of staff and sub category of staffing levels on the system with a text descriptor of what the risk or concern was.<br><br>In the absence of SafeCare, reporting on resourcing is collated via twice daily robust resource huddles.<br><br>Specifically within nursing staff are able to submit unsafe practice forms for review |
| 12IC(2)(b) | These systems and processes include the means for the initial notification / reporting of that risk to the relevant individual with lead professional responsibility. | Green | Systems and processes vary across services. Risk management occurs at team level by a Charge Nurse/ SCN or equivalent. Resourcing risks are reporting via the daily resource huddles and the site safety briefing with membership inclusive of relevant lead professionals. Where safety/resource huddles are not appropriate or routinely used, then individual notification to their lead professional takes place if the risk cannot be mitigated in real time. The Additional Hours Protocol provides a standardised process linked to the resource huddles for daily management of resourcing deficits. |
| 12IC(2)(c) | These systems and processes include the means for mitigation of risk, so far as possible, by the relevant individual with lead professional responsibility, and for that individual to seek, and have regard to, appropriate clinical advice as necessary. | Green | Dynamic risk assessment is inclusive of risk mitigation. Weekly clinical team meetings review each patient's risk and resource requirements. Where appropriate, these risks are reviewed by the RMO on an individual basis with input from the clinical team. Resource associated risks are reported via the twice daily resource huddle. Any risk not safely mitigated is escalated onto the datix system with the reporting line to the staff member's line manager in the first instance. This provides the first level of escalation to the lead with professional responsibility, first opportunity to mitigate the risk and provide clinical input. Severe risks such as a red datix also escalate directly to the executive leadership team. Via the role of Senior Clinical Cover, 24 hour senior clinical advice is available as required. |
| 12IC(2)(d) | These systems and processes include means for raising awareness among all staff of the methods for identifying risk, reporting to the individual with lead professional responsibility , mitigation, and seeking and having regard to clinical advice. | Green | The associated work around creating standardised processes and utilising current reporting, monitoring and risk management systems will support the communication required within the duty. The implementation of SafeCare and MDPJ Tool will also enable us to monitor and report on trends within risk escalation and mitigation. |

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| 12IC(2)(e) | These systems and processes include means for encouraging and enabling all staff to use the systems and processes available for identifying and notifying risk to the individual with lead professional responsibility. | Green | Whilst awaiting the roll out of SafeCare and the implementation of the new MHLD workload tool, TSH ward based resourcing is reviewed on a dynamic basis via daily resource huddles and the role of Senior Clinical Cover. Discussions have been supported with HIS that our robust operational model currently in place provides reassurance that we are compliant with legislation until the roll out of SafeCare. Training for SafeCare will be delivered at the time of implementation.<br><br>All staff have access to the Datix risk management system and can raise a Datix under the category of staff and sub category of staffing levels on the system with a text descriptor of what the risk or concern was. Staff are also able to submit unsafe practice forms to record staff shortages. |
| 12IC(2)(f) | These systems and processes include the means to provide training to relevant individuals with lead professional responsibility on how to implement the arrangements in place to comply with this duty. | Green | Current H&S learning modules on risk assessment and H&S modules for managers and supervisors are currently in place via LearnPro.<br><br>The HCSA implementation team have delivered internal engagement sessions with accountable managers and professional leads.<br><br>Face to face, mandatory training for clinical staff in the management of violence and risk prevention/mitigation is in place.<br><br>Actions plans are developed and recorded to mitigate risk within the H&S Control Book. Training for delivery of this is mandatory for all line managers. |
| 12IC(2)(g) | These systems and processes include means for ensuring that individuals with lead professional responsibility receive adequate time and resources to implement those systems and processes. | Green | Current provision to ensure adequate time is established through staff PDPs, Appraisal Reviews, Job Planning, Time built into Job Descriptions etc. Given TSH is a small board the pool of lead professionals to address all systems and processes is limited. The activity of lead professionals and senior decision makers related to management of risk escalation and management of risk is routinely incorporated into daily work activities.<br><br>Monthly reports are submitted by service leads to the workforce governance group |
| There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met) | | Yellow | An action plan is being developed to support all disciplines achieve compliance with the duty. Significant progress has been made towards compliance within nursing. Development sessions are tabled to advance progress within Medical, Psychology, and AHP |

**Areas of success, achievement or learning**

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

| Area of success / achievement / learning | Details | Further action |
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| This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. | This should describe the situation: what is the success, achievement or learning? For example, areas that have implemented and are using SafeCare are finding it easy to be able to record risks that are identified and the mitigation measures implemented and clinical advice received. Reports extracted from the system are demonstrating an auditable trail of decision-making. | This should describe how the success, achievement or learning could be used in the future. For example, this success is being used to demonstrate to other areas the benefits of using SafeCare and supporting its implementation. |

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| Nursing | Time for Leaders<br>The hospital's review of our Senior Clinical Cover role is ongoing with proposed plans to improve the amount of time available for SCNs to provide ward-based leadership, in addition to supporting the implementation of organizational initiatives and attendance at various groups/committees to ensure nursing representation.<br><br>Charge Nurse engagement with daily resource huddles<br>In August 2023 the Hub Coordinators were invited to attend the daily huddles which allowed the development of the role of the Charge Nurse. We have now progressed this practice where the charge nurse from each ward is expected to attend the daily resource huddles. Their role is to provide a detailed report for their wards nursing resource, unfilled shifts, how these unfilled shifts will be mitigated and a clinical overview of their patients. Collaborative working has empowered this group of staff to make more evidence-based decisions pertaining to safe patient care whilst feeling supported by their peers.<br><br>An improvement piece of work has been undertaken to improve data recording from the daily huddles with the development of a live dashboard which will gather all the required data for operational safety and functioning. The dashboard is in the end stages of testing and it is hoped will Go Live in Q1 of the new financial year. Data presented on the dashboard will provide the hospital with ongoing visuals and trends of the resource challenges by service, ward, and hub and will be used to make evidence-based decisions.<br><br>Real Time Staffing Resource Training<br>Real time staffing training was delivered by HIS for all Charge Nurses and Senior Charge Nurses.<br>From this training it was evident that we had a robust operational model as detailed above in place. The State Hospital decided to concert its efforts in the implementation of Safe Care rather than to implement the RTSR. HIS have provided substantial support to enable us use Safe Care within the ward rosters. All wards are using SafeCare but at different stages. The next step is to consolidate at what point in the implementation journey each ward is at and provide Senior Charges Nurses will the skills to audit the data entered for accuracy within their own area so that we can start to see consistency across all ward rosters and use this information at the daily huddles. | Time for leaders: Continue review of SCC role and deliver actions as determined by review.<br><br>Daily resource huddle: Continue to develop huddle and recording of data in line with HCSA |
| HCSA Compliance | Full engagement with all Clinical Teams is underway to ensure compliance via training and engagement sessions. | |
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**Areas of escalation, challenges or risks**

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

| Area of escalation / Challenge / Risk | Details | Action |
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| This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. | This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with encouraging and enabling certain professional groups to use the systems and processes. | This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in engaging certain professional groups, what measures have been put in place with regard to increasing this such as using professional networks, staff representatives etc. |

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| eRostering | eRostering<br>Health Roster does not link with SSTS or eESS resulting in additional workload and errors. The requirement to run dual systems to ensure safe staffing whilst maximizing the benefits of eRostering is also a challenge as the preferred / priority system is still SSTS due to its paying function of staff salaries. This again creates additional workload.<br><br>The system has limited capacity to report on a site basis – which is current TSH practice. Progress is underway to move from a central resourcing management to a ward based practice however this is not aligned with the TSH eRostering roll out. This work stream involves working in partnership.<br><br>Moving to a customer success model has had its limitations with limited onsite support.<br><br>Moving from a dedicated eRostering Project Team to Business As Usual has slowed down the implementation and evolution of Health Optima and other products such as SafeCare. We are currently reconsidering our priorities of work to be undertaken to meet the needs of the legislation.<br><br>SafeCare<br>Through a recently carried out audit we have identified inconsistency and inaccuracies in recording of data. This may be down to interpretation or the lack of understanding the importance of having up to date and live information in the system. Plans are in place to revisit staff knowledge and skills with a session being delivered by RLDatix on 12/03/2025 to key stakeholders. SafeCare's roll out and its aspiration will need to evolve as we move from a centralized nursing resource style of management to a ward based management.<br><br>Fixed shift patterns<br>Within nursing we have fixed shifts patterns, this does not lend itself to being able to use Health Optima to its potential. The creation of rosters is workload intensive with additional layers of governance. As stated in the duty 121A The State Hospital requires to comply with the nationally agreed pay award to reduce the whole time equivalent working week to 36 hours by April 2026. A short life working group has been establishment to engage with the nursing workforce through face to face sessions and/or via a questionnaire. This engagement will enable us to review our current shift systems and explore opportunities for a single approach to eRostering taking into account flexible working and or flexibility within the shift system, improved wellbeing and more efficiency in the management of the rosters. This will provide additional opportunities to develop a consistent rostering arrangement for all staff and maximise the potential from Health Optima when creating rosters. The engagement sessions are planned to commence in March 2025 for 4 weeks. | Monitor the efficiency of the Business as usual model.<br><br>Discussions on how to move from centralised management of resources to ward based required.<br><br>Utilise national eRostering team support<br><br>Continue audits to ensure good Health Roster practise prior to link with payroll etc. |
| Engagement | All staff are aware of the legislation requirements however, some disciplines are at the start of their journey with real time staffing. Further support is planned via HIS and Senior Nurse Workforce Lead. Consideration of engagement with disciplines that do not have a direct role on patient care, example security, housekeeping, admin etc. | Explore engagement requirements with non-clinical staff |
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**Declaration:** The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

**Level of Assurance:** Please indicate level of assurance provided

Substantial Assurance

**12ID Duty to have risk escalation process in place**

| Section | Item | Status | Comment |
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| 12ID(1) | Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, for the escalation of any risk identified through the real-time staffing assessment processes which has not been possible to mitigate. | Green | The hospital has a clearly defined escalation process to provide guidance and assurance in regards to safe staffing levels. The following below outlines the measures in place in order of escalation and delivery.<br><br>Daily Control Measures<br>Daily Resource Huddle Purpose: to pre-plan daily activity and co-ordinate MDT working (participation includes heads of patient led departments (Skye Centre, AHP, Psychology, Nursing), Senior Clinical Cover, Clinical Resource Administrator, Person Centred Improvement Team, and Business Development Manager). Any escalation or issues from this meeting are taken to the next meeting for authorisation if required Daily Site Safety Meeting- Purpose: To review operational stability across the whole organisation. To discuss any identified areas of risk across the organisation and implement mitigation measures and agree escalations and adaptations to working. Chaired by the Head or Risk and Resilience/On-Call Senior Manager and all relevant operational heads of department attend. This meeting is minute and reports to the CEO and Directors. Hub Co-Ordinators meeting - Purpose: To ensure delivery and implementation of agreed daily operations following the two meetings above, and also ensure co-ordination of activities and staffing across the site. This meeting takes place AM and PM.<br><br>Further Control Measures - Tuesday Resource Planning Meeting (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/Medical Directors), ensuring senior oversight and escalation.<br><br>Weekend planning meeting: Purpose: Dedicated meeting reviewing the upcoming weekend to highlight/discuss available resources, operational issues, review of escalations for overtime, activity plans, contingency plan if required. (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/ Medical Directors), Weekend site safety huddle. Purpose: same as Daily Site Safety(consists of On call director, security, senior clinical cover and on call medical staff). This meeting is minuted and reports to the CEO and Directors. |
| 12ID(2)(a) | These systems and processes include the means for the lead with professional responsibility to report the risk to a more senior decision-maker. | Green | Opportunity for this is covered in the daily resource meeting and the daily site safety as defined above |
| 12ID(2)(b) | These systems and processes include the means for that senior decision-maker to seek, and have regard to, appropriate clinical advice, as necessary, when reaching a decision on a risk, including on how to mitigate it. | Green | As above the attendance of both the resource and the site safety meeting have clinical operational input at Senior Level. |
| 12ID(2)(c) | These systems and processes include the means for the onward reporting of a risk to a more senior decision-maker in turn, and for that decision-maker to seek, and have regard to, appropriate clinical advice as necessary, when reaching a decision on a risk, including on how to mitigate it. | Green | The Site Safety meeting is minuted and sent out each day to all senior operational and clinical managers and also reported directly to the directors and CEO. A further update is also give following the PM hub co-ordinators meeting in regards to resource across patient led and clinical areas. |
| 12ID(2)(d) | These systems and processes include means for this onward reporting in (c) to escalate further, as necessary, in order to reach a final decision on a risk, including, as appropriate, reporting to members of the board of the relevant organisation. | Green | Fully outlined in 121D (1) |
| 12ID(2)(e) | These systems and processes include means for notification of every decision made following the initial report, and the reasons for that decision, to anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice. | Green | The Lead Nurses, who are part of the Daily Site Safety and Daily Resource Meeting take responsibility for any ongoing nurse staffing decisions. If required appropriate escalations will be made to the On-Call Director, who in turn is involved in the daily site safety is then responsible of any changes and escalations and is part of the reporting and requesting process. If required the On-Call Director will brief and other directorate leads or CEO if warranted. |
| 12ID(2)(f) | These systems and processes include means for anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice to record any disagreement with any decision made following the initial identification of a risk. | Yellow | Standard Operating Procedure in place to mitigate risk and support escalation process to effectively manage daily resource, operations, and safety. Daily huddle provides the forum of multidisciplinary discussion of risk and its planning and agreement to mitigate. Datix is in place to oversee and manage risk appropriately with all staff having access. Unsafe practice forms provide a record of disagreement and operational outcomes. The introduction of SafeCare will provide all the information relating to risk and mitigation in the one place. |

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| 12ID(2)(g) | These systems and processes include means for anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice to request a review of the final decision made on an identified risk (except where that decision is made by members of board of the relevant organisation). | Yellow | As detailed above 121D (2) f |
| 12ID(2)(h) | These systems and processes include means for raising awareness amongst all staff of the arrangements stated in (a) to (g) above. | Green | Feedback and direction is given to all operational areas by the operational leads following the decisions reached at the daily resource and also the site safety meeting |
| 12ID(2)(i) | These systems and processes include the means to provide training to relevant individuals with lead professional responsibility and other senior decision-makers on how to implement the arrangements in place to comply with this duty. | Green | Full training in regards to resilience / business continuity is given to all senior leaders with responsibility in the decision making process. |
| 12ID(2)(j) | These systems and processes include means for ensuring that individuals with lead professional responsibility and other senior decision-makers receive adequate time and resources to implement the arrangements. | Green | The Operational Support Plan clearly outlines the steps to be taken for escalation and de-escalation. Each member of staff who has the responsibility within the decision making process is aware of this and has been part of it's production. |
| | There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met) | Green | Self Assessment returns from all service leads for all professions and functions were submitted to the HCSACG and from there an action plan is being developed to support and achieve compliance with the duty. A bench marking exercise will be completed to provide a baseline of compliance across all the professions within the Board - this will be monitored by the HCSACG on a monthly basis. Significant progress towards compliance within nursing. Development sessions are tabled to advance progress within Medical, Psychology, and AHP |

**Areas of success, achievement or learning**

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

| Area of success / achievement / learning | Details | Further action |
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| This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. | This should describe the situation: what is the success, achievement or learning? For example, senior decision-makers in paediatric nursing were identified and chain of escalation communicated to all personnel. Individuals are now much better aware of who to contact during any particular shift in the event that a risk needs to be escalated. | This should describe how the success, achievement or learning could be used in the future. The procedures for identifying the chain of escalation that were used in paediatric nursing are now being trialled and rolled out across other areas. |

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| Operational Support Plan | The hospital has a clearly defined escalation process to provide guidance and assurance in regards to safe staffing levels. The following below outlines the measures in place in order of escalation and delivery.<br><br>Daily Control Measures<br>• Daily Resource Huddle Purpose: to pre-plan daily activity and co-ordinate MDT working (participation includes heads of patient led departments (Skye Centre, AHP, Psychology, Nursing), Senior Clinical Cover, Clinical Resource Administrator, Person Centred Improvement Team, and Business Development Manager). Any escalation or issues from this meeting are taken to the next meeting for authorization if required<br>• Daily Site Safety Meeting- Purpose: To review operational stability across the whole organization. To discuss any identified areas of risk across the organization and implement mitigation measures and agree escalations and adaptations to working.<br>Chaired by the Head or Risk and Resilience/On-Call Senior Manager and all relevant operational heads of department attend. This meeting is minuted and reports to the CEO and Directors.<br>• Hub Coordinators meeting - Purpose: To ensure delivery and implementation of agreed daily operations following the two meetings above, and also ensure co-ordination of activities and staffing across the site. This meeting takes place AM and PM.<br>• The Lead Nurses, who are part of the Daily Site Safety and Daily Resource Meeting take responsibility for any ongoing nurse staffing decisions. If required appropriate escalations will be made to the On-Call Director, who in turn is involved in the daily site safety is then responsible of any changes and escalations and is part of the reporting and requesting process. If required the On-Call Director will brief and other directorate leads or CEO if warranted.<br><br>Further Control Measures<br>• Tuesday Resource Planning Meeting (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/Medical Directors), ensuring senior oversight and escalation.<br>• Weekend planning meeting: Purpose: Dedicated meeting to review the upcoming weekend, to highlight and discuss available resources, operational issues, review of escalations for overtime, activity plans, and contingency plan if required. (Membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/Medical Directors)<br>• Weekend site safety huddle. Purpose: same as Daily Site Safety (consists of on call director, security, senior clinical cover and on call medical staff). This meeting is minuted and reports to the CEO and Directors.<br><br>Tableau Resource Dashboard<br>A resource dashboard is currently in the testing phase for recording escalations of risk and how these are mitigated from the various huddles identified above. This will also provide us with rich information regarding resource trends. Once fully operational this will replace the current use of DATIX.<br><br>Optima and SafeCare<br>Nursing resource practice within the State Hospital is managed centrally with staff being moved across the site to minimize the impact directly on patient care. Our practice of central management means that Optima is not the primary source to manage operations at this time; however steps are being put in place to de-centralize the management of nursing resources to enable Senior Charge Nurses to manage their own nursing resource. Until such change is implemented, current practice requires TSH to run dual systems (from SSTS) to ensure safe staffing during the transition to ward based management within Optima. | Improved data collation, consistent communication and understanding of workforce challenges. |

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**Areas of escalation, challenges or risks**

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

| Area of escalation / Challenge / Risk | Details | Action |
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| This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. | This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with ensuring relevant individuals involved in reporting, mitigating, escalating or giving clinical advice on a risk are notified of decisions made and the reasons for them. | This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in notifying relevant individuals about decisions made and the reasons for them, what measures have been put in place to ensure this happens, such as providing training, increasing awareness and auditing to identify root causes. |

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| eRostering | Some of the challenges that the hospital is working to overcome include:<br>• Health Roster does not link with SSTS or eESS resulting in additional workload and errors.<br>• Rostering demand template in Optima Is linked to the funded establishment for each roster however, there are occasions where the required core shifts are either above or below the funded establishment. Accuracy is reliant on user input and staff are struggling to connect the funded requirement versus the actual resource required via creating/removing additional shifts as needed via a manual process<br>• Dedicated eRostering project team are longer be in place come meaning areas of work are taking longer to progress tasks. | Develop a project Plan with realistic timescales and identified resources |
| HCSA | Identify and agree risks associated with HCSA. | Risk assessment required for HCSA to be added to the Corporate Risk Register |
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**Declaration:** The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

**Level of Assurance:** Please indicate level of assurance provided

Substantial Assurance

**12IE Duty to have arrangements to address severe and recurrent risks**

| Section | Item | Status | Comment |
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| 12IE(1)(a) | Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, for the collation of information relating to every risk escalated to such a level as the relevant organisation considers appropriate. | Green | The hospital has a clearly defined escalation process to provide guidance and assurance in regards to safe staffing levels. The following below outlines the measures in place in order of escalation and delivery.<br><br>Daily Control Measures<br>Daily Resource Huddle Purpose: to pre-plan daily activity and co-ordinate MDT working (participation includes heads of patient led departments (Skye Centre, AHP, Psychology, Nursing), Senior Clinical Cover, Clinical Resource Administrator, Person Centred Improvement Team, and Business Development Manager). Any escalation or issues from this meeting are taken to the next meeting for authorisation if required<br>Daily Site Safety Meeting- Purpose: To review operational stability across the whole organisation. To discuss any identified areas of risk across the organisation and implement mitigation measures and agree escalations and adaptations to working.<br>Chaired by the Head or Risk and Resilience/On-Call Senior Manager and all relevant operational heads of department attend. This meeting is minuted and reports to the CEO and Directors.<br>Hub Co-Ordinators meeting - Purpose: To ensure delivery and implementation of agreed daily operations following the two meetings above, and also ensure co-ordination of activities and staffing across the site. This meeting takes place AM and PM.<br><br>Further Control Measures<br>Tuesday Resource Planning Meeting (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/Medical Directors), ensuring senior oversight and escalation.<br><br>Weekend planning meeting: Purpose: Dedicated meeting to reviewing the upcoming weekend to highlight and discuss available resources, operational issues, review of escalations for overtime, activity plans, contingency plan if required. (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/Medical Directors)<br><br>Weekend site safety huddle. Purpose: same as Daily Site Safety(consists of On call director, security, senior clinical cover and on call medical staff). This meeting is minuted and reports to the CEO and Directors. |
| 12IE(1)(b) | Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to identify and address risks that are considered severe and / or liable to materialise frequently. | Green | Opportunity for this is covered in the daily resource meeting and the daily site safety as defined above |
| 12IE(2)(a) | These systems and processes include the means for recording risks that are considered severe and / or liable to materialise frequently. | Green | As above the attendance of both the resource and the site safety meeting have clinical operational input at Senior Level. Escalations are discussed and decisions are minuted in both forums |
| 12IE(2)(b) | These systems and processes include the means for reporting of a risk considered severe and / or liable to materialise frequently, as necessary, to a more senior decision-maker, including to members of the board of the relevant organisation as appropriate | Green | The Site Safety meeting is minuted and sent out each day to all senior operational and clinical managers and also reported directly to the directors and CEO. A further update is also give following the PM hub co-ordinators meeting in regards to resource across patient led and clinical areas. Any identified risk is discussed and mitigation options are considered. Escalation processes are in place if further measures are required beyond the Site Safety process. |
| 12IE(2)(c) | These systems and processes include means for mitigation of any risk considered severe and / or liable to materialise frequently, so far as possible, along with a requirement to seek and have regard to appropriate clinical advice in carrying out such mitigation. | Green | The Site Safety meeting is minuted and sent out each day to all senior operational and clinical managers and also reported directly to the directors and CEO. A further update is also give following the PM hub co-ordinators meeting in regards to resource across patient led and clinical areas. Any identified risk is discussed and mitigation options are considered. Escalation processes are in place if further measures are required beyond the Site Safety process. |
| 12IE(2)(d) | These systems and processes include means for identification of actions to prevent the future materialisation of such risks, so far as possible. | Green | Our Operational Support Plan clearly defines our process for identification and escalation. Any new identified risk are mitigated and any learning is taken and plans adjusted accordingly. The level of governance around daily staffing ensures any identified actions are carried out and mitigations are delivered. |
| | There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met) | Green | An action plan is being developed to support all disciplines achieve compliance with the duty. Significant progress has been made towards compliance within nursing. Development sessions are tabled to advance progress within Medical, Psychology, and AHP |

The organisation's systems and processes include means for the relevant organisation to have regard to the reports received, with reporting via a standing committee of the Board. The governance structure of the organisation ensures that the organisation has regard to reports created.

**Areas of success, achievement or learning**

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

| Area of success / achievement / learning | Details | Further action |
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| This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. | This should describe the situation: what is the success, achievement or learning? For example, a recurrent risk was identified in the capacity of one laboratory, leading to a delay in testing samples and communicating sample results. Following investigation, the process for booking in samples was streamlined and an admin coordinator was appointed. This has improved performance and the lab is now meeting its targets. | This should describe how the success, achievement or learning could be used in the future. For example, the organisation is now looking at whether the changes implemented in the one lab could be applied to other labs, to improve performance across the division. |
| Operational Support Plan | Operational Support plan is now live and fully operational. The escalation process outlined within the plan is discussed on a daily basis at several risk related meetings across TSH | To be refreshed annually to ensure risks remain relevant and fit for purpose |
| Patients | Patient engagement and feedback is crucial in ensuring we are listening to our service users. This enables us to look at changes to activity or service design. We have an established Patient Partnership Forum which is chaired by the Person Centred Improvement Lead, which strives to have a representative from each ward. Outcomes from this group are fed into the wider governance meetings. Under this group are various sub streams which include a patient representative at each group. Staff also seek views from patients annually on 'What Matters to You' Patients are also represented on the Scottish Health Council. | To continue to include patients and carers in our consultation process in matters which affect their care and treatment. |
| Training Compliance | Key mandatory training is a priority on the organization's risk register. Significant work has been undertaken to recover from COVID and the lack of face to face training events. We are now within a compliant range to meet those targeted training courses such as PMVA & SRK training. | Ongoing monitoring of Training Compliance |
| DATIX | Resource incidents are recorded using our DATIX platform. DATIX is used to record a variety of incidents, events and/or near misses. As noted above, regular reports are provided to the relevant committees detailing trends noted across staffing, including resource-related incidents. Regular reporting ensures that severe and recurrent risks are managed quickly and effectively. Following an increase in a risk, the relevant risk register will be updated and mitigations put in place to reduce the risk again.<br><br>For severe risks, more regular reviews of the risk are required, severe risks are graded as either High or Very High using the national risk matrix and are monitored by the Corporate Management Team and the relevant committees. The hospital also has a Significant Adverse Event Review Process (SAER) which can be utilised to investigate severe incidents to provide learning and ultimately reduce the likelihood of the risk happening again. | Ongoing monitoring |
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**Areas of escalation, challenges or risks**

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

| Area of escalation / Challenge / Risk | Details | Action |
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| This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. | This should describe the situation: what is the challenge or risk identified? For example, collation of data in a particular NHS function has identified a risk that materialises frequently, however identification of actions to prevent future materialisation has not improved the situation. | This should describe what actions have been / are being / will be taken to address the situation. For example, if identification of actions to prevent a frequent risk has not improved the situation, measures to address could have included establishing a working group to investigate and make recommendations, observing practice in the area, interviewing staff, addressing the staff skills mix, allocating additional assistance, redesigning the service etc. |

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| Nothing noted at this time | | |
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**Declaration:** The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

**Level of Assurance:** Please indicate level of assurance provided

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| Substantial Assurance |

**12IF Duty to seek clinical advice on staffing**

| Section | Item | Status | Comment |
|---|---|---|---|
| 12IF(1) | Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to seek and have regard to appropriate clinical advice in making decisions and putting in place arrangements relating to staffing under sections 12IA to 12IE and 12IH to 12IL and to record and explain decisions which conflict with that advice. | Green | Professional leads are in place for all services and provide representation on multiple TSH governance groups, service leadership teams, clinical team meetings, and daily resource huddles.<br><br>The Board operates a model of Triumvirate service management: this consists of Nursing Directorate, Security Directorate and Medical Directorate to ensure TSH service decisions (admission, treatment and recovery, LD, and transitions) are jointly discussed and agreed in collaboration.<br><br>The role of senior clinical cover (provided by and on duty SCN) and the duty RMO are available 24 hours a day for senior clinical advice. In other services it is the most senior clinical leader on duty who provides clinical advice.<br><br>There are different mechanisms to evidence clinical advice has been sought via the daily resource and site safety huddles. Clinical advice related to staffing decisions is fed back via the hub coordinator at hub/ward teams. Data from these huddles is and shared with relevant parties including executive level on a daily basis.<br><br>Additionally, a daily 24 hour report is generated each night highlighting clinical advice given for the preceding 24 hours. This document captures clinical decision making regarding events such as seclusion reviews, observation level reviews, emergency suspension of detention outings, and SRK review. |
| 12IF(2)(a) (i) and (ii) | These systems and processes include the means whereby if a relevant organisation makes a decision which conflicts with clinical advice received, any risks caused by that decision are identified and mitigated so far as possible. | Green | Clinical conflicts are managed and documented through clinical pauses which are then uploaded into the electronic patient record. These Multi disciplinary discussions are reviewed by the Associate Medical Director and Associate Nursing Director and resolved/escalated as required.<br><br>TSH committees and groups provide governance over risks, issues and mitigations which may have arisen from any conflict with clinical advice. |
| 12IF(2)(a) (iii) and (iv) | These systems and processes include the means whereby if a relevant organisation makes a decision which conflicts with clinical advice received, any person who provided clinical advice on the matter is notified of the decision and the reasons for it and this person is able to record any disagreement with the decision made. | Green | All discussions are recorded within various TSH committee/group meeting notes, clinical pauses, meeting minutes or other local processes, and the Associate Medical Director/Associate Nursing Director is sited and involved in that decision making process. Disagreements or concerns would be recorded within these processes to ensure this is auditable and any actions, feedback or further risk assessment can be captured. |
| 12IF(2)(b) | These systems and processes include the means for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the board of the relevant organisation on at least a quarterly basis about the extent to which they consider the relevant organisation is complying with the duties in 12IA to 12IF and 12IH to 12IL. | Green | All clinical leads attend and contribute to the Workforce Governance Group a monthly basis. Risk and issues can be raised at the meetings which are minuted and actions will be generated to ensure compliance. The Workforce Governance Group provides governance to the Board for assurance. The Self Assessment report is generated by the Senior Nurse Workforce Lead and submitted for feedback/further input prior to submission to HIS or Scottish Government. |
| 12IF(2)(c) | These systems and processes include the means for individuals with lead clinical professional responsibility for a particular type of health care to enable and encourage other employees to give views on the operation of this section and to record those views in the  reports to the members of the board of the relevant organisation. | Green | There are a range of ways that we collect feedback form staff, and this will be reflected in compliance monitoring of the different duties in such a report, for example, as detailed in 12IC, 12IH, 12IJ, 12IL.<br><br>There are questions within the staff survey regarding staff opinion on how well they believe their views are listened to and acted upon by the organisation.<br><br>Line Managers also conduct their own staff engagements exercises along professional lines and via iMatter, PDPs, and business meetings. |

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| 12IF(2)(d) | These systems and processes include the means to raise awareness among individuals with lead clinical professional responsibility for a particular type of health care in how to implement the arrangements in this duty. | Yellow | HCSA engagement sessions and training for individuals with lead clinical professional responsibility remain ongoing with support from HIS and the Senior Nurse Workforce Lead.<br><br>Work is commencing on ensuring that the HCSA is introduced to all new starts via their Corporate Induction. SWAY presentation has been shared with all clinical service leads. |
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| 12IF(2)(e) | These systems and processes include means for ensuring that individuals with lead clinical professional responsibility for a particular type of health care receive adequate time and resources to implement the arrangements. | Green | This duty is linked to implementation of Duty 12IH<br>Current provision to ensure adequate time to implement is established through staff PDPs, Appraisal Reviews, Job Planning, Time built into Job Descriptions etc. Given TSH is a small board the pool of lead professionals to address all systems and processes is limited and workload is an ongoing issue. Group/committee reporting/attendance is under review by each department to avoid unnecessary duplication of attendance/workload. Preparation for directorate performance reviews identifies departmental priorities/issues and generates actions to collaborate achieve actions. |
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| 12IF(3) | These systems and processes include means for the relevant organisation to have regard to the reports received. | Green | The governance structure of the HCSA feeds into the Workforce Governance Group with any risks / concerns escalated to the Board. |
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| | There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met) | Green | An action plan is being developed to support all disciplines achieve compliance with the duty. Significant progress has been made towards compliance within nursing. Development sessions are tabled to advance progress within Medical, Psychology, and AHP |

**Areas of success, achievement or learning**

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

| Area of success / achievement / learning | Details | Further action |
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| This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. | This should describe the situation: what is the success, achievement or learning? For example, the views of employees included in the reports prepared by individuals with lead clinical professional responsibility for a particular type of health care identified a potential improvement in working practices in one area. | This should describe how the success, achievement or learning could be used in the future. For example, the potential improvement is being trialled in the one area and if successful will be rolled out across other areas in the organisation. |
| Resource team in place | We are now in the 2nd year of having a resource team to provide operational oversight of clinical resources. This has enabled the SCN's time to focus on their individual clinical area and to foster collaboration with multidisciplinary team members at various forums. SCN's are now invested with time to meet monthly with the Associate Nursing Director and the Senior Management Accountant to develop their knowledge around how their decision making impacts on their budget. A dashboard has been created for each SCN to be able to monitor in post, vacancy, sickness, overtime, use of supplementary staff etc which is already having a positive impact on their decision making. | Develop and support SCN's to become responsible for the staffing within their own ward area. Work has already started with quarterly performance reviews with the Director of Nursing supported by HR and Senior Nurse Workforce. |
| Senior Cover Review | A significant amount of work has been undertaken by the SLWG over the last 12 months working in partnership and with the SCN group to provide clarity on the role that is required. Workload and demand has drastically reduced with the resource team in place as well as refocusing on who should be delivering what. We are confident this review will be concluded within Q2 of the new financial year. | Continue to support the SCN's to develop as clinical leaders. |
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**Areas of escalation, challenges or risks**

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

| Area of escalation / Challenge / Risk | Details | Action |
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| This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. | This should describe the situation: what is the challenge or risk identified? For example, in compiling the reports made to the members of the Health Board, there are good mechanisms in place for the Medical Director to enable and encourage medical employees to give their views, but the mechanisms for seeking the views of other professional groups for which they are responsible, such as pharmacy employees, are not well established. Hence, the views of these employees are not being sought or incorporated into the reports. | This should describe what actions have been / are being / will be taken to address the situation. For example, if the views of all professional groups are not being sought, what measures have been put in place to engage these groups and proactively seek out their opinions. |
| MHLD tool | Alongside HIS a temporary workload an abridged task list has been developed to ensure compliance with the act whilst a fit for purpose MHLD tool is being developed. This workload task list has successfully been tested within two wards within the TSH (Iona 2 and Lewis 1). This requires to be rolled out to the other 8 wards with a tool run date agreed for this financial year. | A 2 week tool run was achieved in March 2025 across all 10 wards. |
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**Declaration:** The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

**Level of Assurance:** Please indicate level of assurance provided

Substantial Assurance

**12IH Duty to ensure adequate time given to clinical leaders**

| Section | Item | Status | Comment |
|---|---|---|---|
| 12IH | Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to ensure that all individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to discharge that responsibility and their other professional duties. | Green | Job Planning is in place for medical employees.<br>All other professions out with medical, have leadership time monitored through one-to-one meetings and the PDPs held between manager and clinical leaders. PDP completion rates are monitored by the Workforce Directorate department.<br>All services/professions are benchmarking the duty to ensure adequate time is given to leaders however this can be challenging due to the small nature of the board and the same people tasked with organisational priorities. |
| 12IH | These systems and processes include time and resources for these individuals to supervise the meeting of the clinical needs of patients in their care; to manage, and support the development of, the staff for whom they are responsible; and to lead the delivery of safe, high-quality and person-centred health care. | Yellow | Through the measures outlined above, as well as line management and professional leadership support at all levels, clinical leaders will be supported to have the time and resources to undertake these roles, or seek support and highlight risks where this is not sufficient.<br><br>MDPJ and RTSRs are currently being explored for AHP and Psychology with the support of HIS. Training has been delivered to the service leads and a plan for implementation is being developed. |
| 12IH | These systems and processes include the means to identify all roles, and therefore individuals, with lead clinical professional responsibility for a team of staff. | Green | Lead clinicians are identified via multiple TSH systems such as LearnPro, SSTS, eEES, and TURAS. Staff job descriptions reflect the specific leadership responsibilities, requirements and expectations within each role which are managed by relevant line managers. Work has progressed within nursing with skills identified within eRostering to aid staff being allocated in the right place at the right time. |
| 12IH | These systems and processes include the means to determine what constitutes sufficient time and resources for any particular individual. | Green | This will be done as part of the job planning process, TURAS, and PDPs. Staff and line managers are able to escalate in the event of risk to quality and safety as required. |
| 12IH | These systems and processes include the means for ensuring this duty has been reviewed and considered within the context of job descriptions, job planning and work plans, as appropriate. | Green | As described above, job descriptions, job planning and work plans are all assessed at appropriate times via appraisal, 1:1s and PDP, job planning, development sessions, service change and redesign.<br>Job planning sign off completion rates can be monitored through their respective systems. Workforce Governance reports are provided monthly to all service leads to highlight areas of risk such as hard to fill posts, vacancies, onboarding and leavers. |
| 12IH | These systems and processes include the means to consider outputs from activities carried out to meet this duty in order to inform future workforce planning and protect the leadership time required for clinical leaders. | Yellow | Access to eRostering systems to support workforce planning is currently being rolled out within. During this transition period, all professional leads have access to annual PDPs/appraisals and medics have access to job planning. Discussion time with line managers to agree levels of time and resource to discharge their responsibilities and clinical workload are a core component of annual appraisal meetings and are escalated as required via board governance structures. Appraisal completion rates are monitored by the workforce governance group. |
| | There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met) | Green | An action plan is being developed to support all disciplines achieve compliance with the duty. Significant progress has been made towards compliance within nursing. Development sessions are tabled to advance progress within Medical, Psychology, and AHP |

**Areas of success, achievement or learning**

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

| Area of success / achievement / learning | Details | Further action |
|---|---|---|
| This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. | This should describe the situation: what is the success, achievement or learning? For example, senior physiotherapists and team leaders convened a working group to determine what sufficient time and resources would look like for individuals with lead clinical professional responsibility for a team of staff. The outcome of the project was a determination of time and resources for different team leaders, and feedback so far has been positive. | This should describe how the success, achievement or learning could be used in the future. This has now been extended to other AHP areas and trialled to see applicability. |

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| Management Redesign | A couple of senior posts within the Nursing Directorate became vacant, which provided an opportunity to revise the portfolios and consider where we required to use the funding from these posts in a different way. There was an identified need to strengthen the operational management within the directorate, as well as free up lead nurses to increase the focus on supporting the professional and clinical aspects of practice. Therefore, we aim to introduce two service manager posts to the directorate and they will assume line management responsibility for the SCNs and responsible and accountable for the operational service delivery. Recruitment of these posts is planned for early in the new financial year. | Prepare Job descriptions and advertise posts. |
| Nursing director supported absence review meetings | Over the last 12 months a significant investment has been made to support our SCN's and CN's develop into their role as clinical leaders. An area of concern was the level of sickness absence and to ensure we had robust systems in place to manage this. Along with the introduction of 'Once for Scotland' Policies and a task and finish group, SCN's now have monthly meetings with Human Resources to ensure staff are being supported appropriately whilst absent. Improvements have been noted however we are still above the 5% P.A.A. | Continue to develop these meetings, monitor trends, and tailor to individual needs |
| Heads of clinical department development day. Psychology have held development days to focus on planning for new clinical model. Have also introduced weekly consultant huddles. | Psychologists will have time allocated as part of their workplan for leadership duties. AHP's will have time allocated as per their job descriptions/work plans.<br><br>Development days in progress to create joined up working and team building. Each service has an allocated lead for psychology who is also a member of the Service Leadership Teams. They will have oversight of the clinical needs of the service and how these are to be met. Care will be delivered in line with the national psychology specification and the Matrix. Governance of this will be through the HoP. | Ongoing programme |
| AHP Clinical Leads monthly meeting to focus on service planning and delivery. | AHP dedicated development sessions to enhance service planning and delivery. AHPS have senior clinicians allocated to each service and who are members of the SLT. As with psychology they have oversight of the clinical needs of the AHP services and governance via Lead AHP. | Ongoing programme |
| Financial Review Meetings | In preparation for SCN's to have the autonomy to be budget holders for their ward area the Director of Nursing introduced monthly Finance Meetings led by the Senior Management Accountant. Due to the way in which deficits are covered by overtime or excess hrs SCN's needed to have an overview of how this management was having an impact on their budget. A dashboard Hs been developed for each ward and provides key information re sickness absence, overtime, unfilled shifts etc which can also be monitored over time for trends. These dashboards have been up and running for 6 months. | Continue to develop these meetings, monitor trends, and tailor to individual needs |

**Areas of escalation, challenges or risks**

| Area of escalation / Challenge / Risk | Details | Action |
|---|---|---|
| This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. | This should describe the situation: what is the challenge or risk identified? For example, the process in place to identify the roles, and therefore individuals, with lead clinical professional responsibility for a team of staff does not consistently identify who these individuals are, and therefore sufficient time and resources for these individuals to discharge their responsibilities has not been considered. | This should describe what actions have been / are being / will be taken to address the situation. For example, if the process in place to identify the roles, and therefore individuals, does not consistently identify who those individuals are, what measures have been taken to address this? e.g. working with all staff groups / clinical areas / teams to identify job titles / roles, utilising HR processes and data, utilising eRostering to identify team leaders etc. |
| Small board | Small board – majority of organisational tasks become the remit of a small group of the same senior individuals to take forward, can become person-dependent. Due to the size of the board, streamlining of meetings has proved challenging. | Streamlined reporting processes freeing up staff as best we can, eg Lead Nurses have been assigned different key areas of responsibility and meetings to which they are required to attend. |

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| Wellbeing of staff | Wellbeing of all staff. Lots of good support being provided however, workload makes it very difficult to attend/utilise excellent resources. | Wellbeing is a focus within the Nursing Directorate, SCN meetings with Director of Nursing have identified a need to consider how we support the well being of a Senior Charge Nurse who due to workload doesn't find time for themselves. |
| 36 Working Week | Progression towards a 36-hour working week is noted as a risk factor in ensuring protected time for learning however the implications of this are being monitored through the hospitals Workforce Governance Group which meetings monthly, with Short Life Working Groups in place meeting more frequently when required. | Preliminary work underway. Awaiting national guidelines |
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**Declaration:** The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

**Level of Assurance:** Please indicate level of assurance provided

Reasonable Assurance

**12II Duty to ensure appropriate staffing: training of staff**

| Section | Item | Status | Comment |
|---|---|---|---|
| 12II | Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to ensure that all employees receive such training as considered appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b) and such time and resources as considered adequate to undertake this training. | Green | TSH education teams for professions provide educational support through Practice Development/Education Facilitators (Nursing, medical and AHP specific) and identified development, learning facilitators in other professions to deliver identified new knowledge and skills requirements. All new employees undergo corporate induction and orientation.<br>Workforce Directorate monitor and report on all staff training to ensure compliance. This includes all face to face mandatory training, PDP completion, and LearnPro modules. This is reported via local governance routes including Staff Governance, Workforce Governance, partnership forum and directorate performance frameworks.<br>Training on legislation delivered at each tool implementation – leads, seniors and clinical staff with responsibility to implement. |
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| 12II | These systems and processes include means to determine the level of training required, and time and resource to support this, for all relevant employees. | Green | Training within the organisation is clearly determined along the lines of Mandatory, Essential and Development requirements for each profession and role.<br><br>All training is support with protected time to complete and all training requirements, resources and protected time is agreed within PDPs.<br><br>Different professions have different set national training curriculums. These are supported through line management and departmental budgets. |
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| 12II | These systems and processes include the means to deliver the agreed level of training to all relevant employees. | Green | TSH education teams for professions provide educational support through Practice Development/Education Facilitators (Nursing, medical and AHP specific) and identified development, learning facilitators in other professions to deliver identified new knowledge and skills requirements. PDP completion monitored through TURAS platform along with completion of mandatory and essential training at one to one meetings between managers and staff within all professions. |
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| 12II | These systems and processes include the means to ensure all relevant employees receive both time and resources to undertake the training. | Green | Time allocated for training is protected time. All disciplines are supported to attend face to face mandatory and statutory training. Nursing staff are issues with their off duties every six week and these off duties include rostered shifts for training. All other staff are managed by the learning and development timetable of when they are due to attend training – this is supported by line managers.<br>Flexible approach to staff completion of online learning access to training available from multiple devices and locations including areas out with the clinical setting. Access to online learning, Staff can choose when to complete e learning. The learning and development department monitor and report on training compliance and if necessary, risk is escalated to the corporate risk register. |
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| | There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met) | Green | An action plan is being developed to support all disciplines achieve compliance with the duty. Significant progress has been made towards compliance within nursing. Development sessions are tabled to advance progress within Medical, Psychology, and AHP |

**Areas of success, achievement or learning**

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

| Area of success / achievement / learning | Details | Further action |
|---|---|---|
| This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. | This should describe the situation: what is the success, achievement or learning? For example, the psychology division, in conjunction with HR, has just completed a project to promote more accurate capturing of information relating to continued professional development for psychology colleagues. Feedback from employees is that they have found the new system much easier to use and are now recording relevant CPD. | This should describe how the success, achievement or learning could be used in the future. AHP colleagues have now expressed interest in the new system and are undertaking a project to see if they could implement something similar. |
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| Learning & Development | A corporate training programme exists and is reviewed annually by service leads to ensure all statutory and mandatory training is current and relevant. Compliance reporting and monitoring is embedded within the directorate performance framework. | Staff will have their training records uploaded into Health Roster. |

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| | Courageous conversation training is being delivered to Charge Nurses /SCN' s to support them manage absence. This along with the Once For Scotland policies has enabled mangers to understand other available options for absence and how they can be supported make flexible decisions to support staff. | During the quarterly meetings with SCN's reflect on the use of the policies and learn from shared experience. |
| Nursing | Rostering practices with senior Clinical staff have improved with training and development. This will continue to be supported by the implementation of eRostering. A more consistent picture being seen when rostered are presented for approval. Learning and development attend the weekly resource planning sessions where any with training/resourcing are discussed and solutions found. | Continue to work closely with the Learning and Development Team ensuring we are proactively managing staff training |
| HR | Once for Scotland Policies awareness sessions completed and HR department are now actively supporting line managers to utilise the new policies. Each department head has an allocated HR advisor to ensure consistent application of policies. Further organisational training regarding HR matters continues including – investigation training, counter fraud training etc. | Ongoing review of training delivered and continuing support from HR advisors. |

**Areas of escalation, challenges or risks**

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

| Area of escalation / Challenge | Details | Action |
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| This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. | This should describe the situation: what is the challenge or risk identified? For example, clearly defined processes and procedures exist for some groups of staff, e.g. nursing and midwifery, but don't exist for other groups of staff, e.g. healthcare scientists. | This should describe what actions have been / are being / will be taken to address the situation. For example, if procedures and processes are not in place for healthcare scientists, what measures need to be put in place to ensure this?; such as working with HR and healthcare scientist representatives to define an appropriate training programme, assess training needs of employees and plan for required training to be undertaken. |
| Increased Clinical Acuity | Training is now considered in the weekly resource meeting, to ensure oversight of our risk escalation processes when training is cancelled. Training is generally cancelled when severe resourcing issues are evident and to minimise the impact to patient care. This can be the cause of increased clinical acuity or boarding out. | To ensure those staff whose training is cancelled is rearranged at the earliest opportunity. |
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**Declaration:** The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

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| **Level of Assurance:** Please indicate level of assurance provided | The challenge of not having all services and professions using the same systems is creating variability, and timelines for full implementation is over 2 years. | Continue to support and promote eRostering implementation, and articulate the interdependency between the Act and eRoster. Mitigation of risk is via good governance and engagement with all services through self-assessment returns, which are in use quarterly. Staff can continue to access the operational and professional structures in place to support practice.. Datix is available to all staff to record any associated adverse events. |
| **Ability to record and report on all activity** | There are robust structures, processes and SOPs in place to support this duty, however there is no consistent method for recording an reporting on this in the absence of SafeCare (linked to above). | As above. |

Substantial Assurance

**12IJ Duty to follow the common staffing method**
(*The relevant organisation **must only** report on the types of health care, location and employees as detailed in section 12IK)

| Section | Item | Status | Comment |
|---|---|---|---|
| 12IJ(1) | Clearly defined systems and processes are in place, and utilised, in all the types of health care, locations and employees listed in section 12IK, to follow the common staffing method no less often than the frequency prescribed in Regulations (see https://www.legislation.gov.uk/ssi/2024/43) | Green | TSH is currently using an abridged version of the MHLD & Professional Judgement tool whilst the new tool is named on October 2025. This abridged version will ensure compliance and enable us to carry out a 2 week tool run. The TSH were identified to take part in the Observational studies to support the development of this MHLD tool.<br><br>Access to resources includes: HIS speciality specific toolboxes, training videos, templates FAQs as well as real time face to face support from the dedicated team within the Board. |
| 12IJ(2)(a) | These systems and processes include use of the relevant speciality specific staffing level tool and professional judgement tool as prescribed in Regulations (see https://www.legislation.gov.uk/ssi/2024/43), and taking into account results from those tools. | Green | MHLD & Professional Judgement tool is approved for use however as above; HIS continue to provide support, training, and development updates in conjunction with TSH's Senior Nurse Workforce Lead. |
| 12IJ(2)(b) | These systems and processes include taking into account relevant measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H(1) of the 1978 Act by the Scottish Ministers (including any measures developed as part of a national care assurance framework). | Green | A range of quality measures such as Clinical Quality Indicators, patient safety data, KPIs, risk assessments, physical health steering group, and annual delivery plan etc. are utilised for CSM triangulation and input into workforce. In addition, clinical quality monitor and report on clinical incidents, risk, daytime confinement, complaints/compliment etc. on a monthly basis via various governance routes within TSH. |
| 12IJ(2)(c)(i) | These systems and processes include taking into account current staffing levels and any vacancies | Green | Funded establishment, actual staffing (including vacancies/onboarding) is reported via a monthly workforce report. BOXI provides a viable reporting mechanism to monitor the use of additional hours and the PAA absence. With the continual roll out of eRostering new reports features become available. |
| 12IJ(2)(c)(ii) | These systems and processes include taking into account the different skills and levels of experience of employees | Green | Nursing Ward funded establishments are reviewed regularly to ensure the appropriate gender/skill/experience is in place to support CSM. Ongoing recruitment takes into consideration the age profile and gender/skill requirements and this is reported monthly via the workforce report. TSH aspires to recruit to a 60/40 registered/non registered split. |
| 12IJ(2)(c)(iii) | These systems and processes include taking into account the role and professional duties of individuals with lead clinical professional responsibility for the particular type of health care. | Green | In the absence of a viable MHLD tool (as described above) TSH have adopted an abridged version of the tool which is verified by HIS, This enables TSH to adequately be able to meet reporting requirements. |
| 12IJ(2)(c)(iv) | These systems and processes include taking into account the effect that decisions about staffing and the use of resources taken for the particular type of health care may have on the provision of other types of health care (particularly those to which the common staffing method does not apply). | Green | Reports are submitted to TSH oversight groups for review including Workforce Governance and Clinical Governance. Group members include a wide range of multi professionals who can review patient delivery of care and consider any potential impact of changes to delivery of patient care from an MDT approach. |
| 12IJ(2)(c)(v) | These systems and processes include taking into account the local context in which health care is provided. | Green | Again, in the absence of a viable MHLD tool, the local context of for each clinical service is fed into the daily resource huddles with data captured. Each area is able to input concerns around skill mix, psychological safety results, staff experiences, capacity and demand, and supplementary staffing usage.<br><br>Line management is able to review areas such as missed care results, imatter scores, staff experiences, age profile of employees, capacity and demand, PAA v actual, etc. Reporting of areas of concern are escalated via the Workforce Governance Group. |
| 12IJ(2)(c)(vi) | These systems and processes include taking into account patient needs. | Green | Patient needs are considered at local level by line management and a weekly clinical team meeting. On a daily basis, specific patient needs and activity are considered at the resource huddles to minimise the risk to patient care.<br>In addition, the patient voice is considered and managed via the Person Centred Improvement Team via the Patient Partnership Group which includes patient representation. This group is externally supported by the Scottish Health Council. |

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| 12IJ(2)(c)(vii) | These systems and processes include taking into account appropriate clinical advice. | Green | Clinical advice from involved professionals is sought via the weekly clinical team meetings, service leadership teams, clinical pauses, and the daily resource huddles. Out of hours, clinical advice is provided by the role of Senior Clinical Cover, on call medica, and an on call director. |
| 12IJ(2)(c)(viii) | These systems and processes include taking into account any assessment by HIS, and any relevant assessment by any other person, of the quality of health care provided. | Green | Clinical advice from involved professionals is sought via the weekly clinical team meetings, service leadership teams, clinical pauses, and the daily resource huddles. Out of hours, clinical advice is provided by the role of Senior Clinical Cover, on call medica, and an on call director. |
| 12IJ(2)(c)(ix) | These systems and processes include taking into account experience gained from using the real-time staffing and risk escalation arrangements under 12IC, 12ID and 12IE. | Yellow | At present, risk is reported via Datix and via unsafe practice forms. |
| 12IJ(2)(c)(x) | These systems and processes include taking into account comments by patients and individuals who have a personal interest in their health care, which relate to the duty imposed by section 12IA. | Green | TSH has a robust patient partnership forum which has patients from each hub acting as a voice for the patients within their own areas and ensuring feedback of provided. Person Centred Improvement Team collates and reports on the patient and carer experience and these are used in the triangulation of CSM. The Mental Welfare Commission and the Scottish Health Council provide support to this forum and provides assurance the patient/carer voice is heard. |
| 12IJ(2)(c)(xi) | These systems and processes include taking into account comments by employees relating to the duty imposed by section 12IA. | Green | Staff feedback is gathered via a staff survey, 1:1s with line managers, What Matters To You, PDPs, and business/departmental meetings and will be captured during the roll out of SafeCare. |
| 12IJ(2)(d) | These systems and processes include means to identify and take all reasonable steps to mitigate any risks. | Green | In the absence of SafeCare, risk is reported via Datix, unsafe practice forms and a robust operational resourcing model as described in 121A. |
| 12IJ(2)(e) | These systems and processes include means to decide what changes (if any) are needed to the staffing establishment and the way in which health care is provided as a result of following the common staffing method. | Green | Changes to staffing establishments are reviewed in conjunction with service redesign, workforce planning input, clinical/professional advice. These changes are reported and monitored through workforce governance group and if necessary escalated to the Board. |
| | There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met) | Green | An action plan is being developed to support all disciplines achieve compliance with the duty. Significant progress has been made towards compliance within nursing. Development sessions are tabled to advance progress within Medical, Psychology, and AHP |

**Areas of success, achievement or learning**

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

| Area of success / achievement / learning | Details | Further action |
|---|---|---|
| This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. | This should describe the situation: what is the success, achievement or learning? For example, application of the common staffing method in adult inpatient provision identified some areas where the staffing establishment needed to be changed, and some areas with potential for service redesign. These changes are now in progression and will be trialled to monitor the outcomes. | This should describe how the success, achievement or learning could be used in the future. For example, following completion of the trials regarding changes in staffing establishment and service redesign, decisions will be taken as the changes made. These could then be used as case studies to inform training for staff about the use of the common staffing method. |

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| Nursing | • The Monthly workforce report has evolved to provide us with a range of workforce information including vacancies, hard to fill posts, secondments, fix term, leavers and retire and returns.<br>• Alongside HIS a temporary workload task list has been developed to ensure compliance with the act whilst a fit for purpose MHLD tool is being developed. This workload task list has successfully been tested within two wards within the TSH (Iona 2 and Lewis 1). This requires to be rolled out to the other 8 wards with a tool run date agreed for this financial year.<br>• Awareness sessions have been delivered to Iona Hub on the Common Staffing Method. Plans to expand this to all other areas will run in conjunction with the role of the abridged MHLD tool.<br>• The supplementary staffing register has remained static in the last 3 months and discussions around the use of year 2 nursing students is being explored. Changes to pension plans has allowed experienced staff to return as full time members of staff whilst partially retiring. This provides a vehicle to ensure experience, skills, and gender are being maximized.<br>• A 6 month test of change is currently in place to resource a Band 3 post to work alongside the Outings Coordinator to minimize the impact on wards to resource planned outings on a daily basis. Initially data is proving positive with a dramatic reliance on ward based staff to, fill this activity.<br>• Day time Confinement (DTC) continues to be monitored.<br>• Senior members of nursing are present at all forums across TSH including the daily resource huddles to allow feedback to staff on issues surrounding staffing, gender, skill mix and DTC.<br>In addition, charge nurses now attend all daily resource huddles for input and work collaboratively to help manage resources efficiently and to minimise the effect on patient care due to DTC.<br>• Observational studies took place from April – June 2024 across 7 wards. A presentation was delivered to the expert working group in February 2025 providing the outcomes of the study and areas for learning. Each board will receive a detailed report of their engagement in the process. This study will help shape and develop the new MHLD tool to be named in legislation.<br>• The State Hospital is involved in the national evaluation testing of the MHLD Inpatient staffing Tool and that this has been a good opportunity for staff to see the benefits of SafeCare. 4 wards were identified, one from each specialty, the first test run was in November 2024, however there were some interpretational issues relating to the application of Levels of Care document shared. Following discussion with HIS a rerun of the testing took place in January 2025. No feedback from HIS has been received to date. | Workforce report shares data highlighting vacancies across the clinical area looking at skills, gender, experience. This report supports managers to be proactive around recruitment which hopefully will reduce gaps in vacancies. HR support planning ahead for any known leaver or planned retirements that can be considered for proactive recruitment. HR have developed a redeployment register for staff who are unfit/not appropriate for substantive role – this allows use of their skills in different areas.<br><br>Work in conjunction with HIS to undertake observational studies to aid the development of available MHLD tool.<br><br>This HCSA Compliance Act Group will report directly to Workforce Governance Group and have a detailed work plan to ensure we are working on the areas required to meet the legislation.<br><br>Further training is required to be delivered to clinical leaders on the use of the common staffing method.<br><br>Continue to promote positive engagement and feedback to the workforce on areas of staffing levels, risk and escalation. |
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**Areas of escalation, challenges or risks**

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

| Area of escalation / Challenge / | Details | Action |
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| This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. | This should describe the situation: what is the challenge or risk identified? For example, the common staffing method was followed at the required frequency in all areas except emergency care provision with an explanation of why this was not completed, e.g. lack of knowledge / training of personnel. | This should describe what actions have been / are being / will be taken to address the situation. For example, if the common staffing method was not followed in emergency care provision and this was due to lack of knowledge / training, what measures were put in place to address this, e.g. identifying key personnel, provision of training, assistance from experienced personnel in other areas etc. |
| Gender sensitive tool | The existing Gender sensitive tool used within the hospital has been in place for approximately fifteen years and requires a full review, in line with the principles of the Health and Care Staffing Act. SafeCare will support us with this when fully embedded. | Review when SafeCare implemented |
| MHLD Tool | Alongside HIS a temporary workload an abridged task list has been developed to ensure compliance with the act whilst a fit for purpose MHLD tool is being developed. This workload task list has successfully been tested within two wards within the TSH (Iona 2 and Lewis 1). This | All |
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**Declaration:** The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

**Level of Assurance:** Please indicate level of assurance provided

Substantial Assurance

**12IL Training and consultation of staff**
(*The Health Board and Agency **must only** report on the types of healthcare, location and employees as detailed in section 12IK)

| Section | Item | Status | Comment |
|---|---|---|---|
| 12IL | Clearly defined systems and processes are in place, and utilised, in all the types of health care, locations and employees listed in section 12IK, for the training and consultation of staff. | Green | HCSA is incorporated within the corporate training plan 2025-2026. There is a requirement to adapt NES, HIS, and Turas resources to ensure they reflect TSH systems and procedures.<br><br>HIS continue to support the testing of a new MHLD tool which will be in place for October 2025. In the meantime, the abridged version has been verified and used during our 2 week MHLD Tool run. CSM awareness sessions have been developed in line with the implementation and planned roll out of SafeCare.<br><br>All SCNs and charges nurses have access to TURAS resources and HIS learning. |
| 12IL(a) | These systems and processes include means to encourage and support employees to give views on staffing arrangements for the types of health care described in section 12IK. | Yellow | Preliminary discussions are required to develop an eLearning resource which will be inclusive of ways to provide feedback. Additionally, the incorporation of a feedback option within iMatter is being explored. Staff surveys allow opportunity for staff to provide feedback alongside business meetings and 1:1 with line manager.<br><br>Daily resource huddles allow full discussion of staffing risks, mitigations, and positive/negative outcomes. |
| 12IL(b) | These systems and processes include means for taking into account and using views received to identify best practice and areas for improvement in relation to staffing arrangements. | Green | Staff involvement encouraged and evidenced via iMatter, PDPs, staff surveys, and training evaluation forms.<br><br>Daily resource huddles provide opportunities for staff to engage in solution oriented collaborative working. Feedback from these meetings is delivered at hub level by the attending hub coordinator.<br><br>Abridged version of the MHLD was developed in consultation and engagement with Iona 2/Lewis 1 SCNs and charge nurses. Feedback has been provided to HIS and modifications to the tool have been adjusted. |
| 12IL(c) | These systems and processes include training employees (in particular those employees of a type mentioned in section 12IK) who use the common staffing method on how to use it. | Green | Local face to face or teams training sessions are delivered as part of the preparation for any tool run. A local training package is also being developed which will be mandatory for all staff in scope of legislation. Staff are encouraged to complete HIS TURAS learning resources. |
| 12IL(d) | These systems and processes include ensuring that employees who use the common staffing method receive adequate time to use it. | Green | Adequate time to undertake CSM duties will be monitored and assured via one-to-one meetings and the PDPs held between manager and clinical leaders. All services/professions are benchmarking the duty to ensure adequate time is given to leaders however this can be challenging due to the small nature of the board and the same people tasked with organisational priorities. |
| 12IL(e) | These systems and processes include providing information to employees engaged in the types of health care mentioned in section 12IK about its use of the common staffing method, including the results from the staffing level tool and professional judgement tool; the steps taken under 12IJ(2)(b), (c) and (d) and the results of the decisions taken under 12IJ(2)(e). | Yellow | With the introduction of SafeCare and the new MHLD Tool in October 2025 a robust training plan will be developed with a specific focus on those staff engaging in the CSM process. |
| | There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met) | Green | An action plan is being developed to support all disciplines achieve compliance with the duty. Significant progress has been made towards compliance within nursing. Development sessions are tabled to advance progress within Medical, Psychology, and AHP |

**Areas of success, achievement or learning**

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

| Area of success / achievement / learning | Details | Further action |
|---|---|---|
| This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. | This should describe the situation: what is the success, achievement or learning? For example, key personnel who were very experienced in using the common staffing method were engaged to train and mentor other personnel involved in the process. | This should describe how the success, achievement or learning could be used in the future. For example, those key personnel have now decided to meet regularly in a forum to discuss shared learning and to ensure the common staffing method is used consistently across all relevant areas in the organisation. |
| Learning & Development | • A corporate training programme exists and is reviewed annually by service leads to ensure all statutory and mandatory training is current and relevant. There is input from all Heads of Service. Compliance reporting and monitoring is thereafter embedded within each Directorate Performance framework and monitored through the monthly Workforce Governance meetings.<br>• eRostering is now being used across 34/42 rosters within TSH. Areas using the system are keeping the system live on a day to day basis with minimal rosters utilizing additional functionality. Nursing rosters have been developed from the initial RLDatix build to fit TSH practice however, at present nursing are not seeing the benefits of the system with workload related to double keying of data being cited as an area of concern.<br>• Consultation with staff continues to improve with the strengthening of nurse membership engagement at resource forums. This has also enabled a process for hub based staff to raise staffing concerns/queries and receive feedback either in person or by formal communication.<br>• There has been significant workforce undertaken to engage with our workforce focusing on staff wellbeing and development. This work has helped to inform our Organizational Development Strategy.<br>• Training and Professional development manager alongside the Senior Nurse – Workforce Planning have developed a training session for registered nurses on the consistent application of the common staffing method. This will commence in Q1 of the new financial year.<br>• The SWAY presentation has been shared to all service leads as a useful resource | Discussion underway with the Training and Professional development manager to include the common staffing method as part of the mandatory training for registered nurses which will be part 1 of the training process, staff will then be supported to apply the tool consistently. Training resources need to be adapted to the TSH to allow accurate recording of training compliance.<br><br>With the implementation of Safe Care staff we will have additional routes to escalate risk instead of only Datix reporting.<br><br>Continue to develop our communication and engagement strategies with ward based staff to ensure inclusion.<br><br>SWAY presentation has been shared with nursing leaders as a useful resource. |
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**Areas of escalation, challenges or risks**

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

| Area of escalation / Challenge / | Details | Action |
|---|---|---|
| This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. | This should describe the situation: what is the challenge or risk identified? For example, issues were identified with the lack of training and adequate time for personnel in emergency care provision. | This should describe what actions have been / are being / will be taken to address the situation. For example, arranging and delivering training, provision of mentoring from experienced personnel, job planning to ensure adequate time is available for designated personnel to follow the common staffing method. |

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| Nursing | • The eRostering implementation roll out across the hubs has taken longer than predicted due to the significant challenges we have encountered in this process. This continues to be an ongoing challenge with the eRostering dedicated support being under review. The current focus is to developing a business as usual model.<br>• We have agreed to move away from a centralised approach to managing resourcing and have SCNs in charge of their wards. This has proved challenging due to the review of senior clinical cover not having been completed to provide them with capacity to fully manage their own areas. The absence of SafeCare within the eRostering roll out means that TSH is reliant on existing operational mechanisms to manage resources. Whilst this move to a ward based management has been challenging, we have seen a shift in a positive direction towards hub based management via the inclusion of the CN's and medics at the daily resource huddles. | eRostering team to develop business as usual model and implement.<br><br>Processes in consultation with staff are required whilst we make this decentralisation to provide assurance that we are confident we have the right staff arriving for work. |
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**Declaration:** The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

**Level of Assurance:** Please indicate level of assurance provided

Reasonable Assurance

**1 Guiding principles for health and care staffing**
**2 Guiding principles etc. in health and care staffing and planning**

**RAG status**

| Section | Item | Status | Comment |
|---|---|---|---|
| 2(2) | Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups to ensure that when the relevant organisation is planning or securing the provision of health care from a third party, it has regard to the guiding principles for health and care staffing and the need for that third party from whom the provision is being secured to have appropriate staffing arrangements in place. | Green | Guiding principles and staffing arrangements are considered when planning and securing services - work is ongoing with procurement colleagues to ensure that this is clearly set out in the processes and can be evidenced to support annual reporting.<br><br>In addition, procurement of health care services from another provider falls within the SG guidelines whenever a SLA or other agreements are signed. |

**Please provide information on the steps taken to comply with section 2(2)**

These are steps taken to comply with 2(2) in general. Examples could include information about procurement and commissioning processes, how the guiding principles are taking into account and what procedures are in place for obtaining information about staffing arrangements.

As a small Special Health Board we have a number of long standing SLA's in place with other local Territorial Boards. These are reviewed after around 3 years and the budget holder/stakeholder will discuss with the provider the staffing levels and skills required. They will then work with Procurement around costs and other considerations such as service providers personnel clauses, scope of service, data protection, confidentiality of Caldicott, compliance with legal obligations etc and a new SLA would then be drafted and signed by both parties. In the rare occasion when more than one Board can provide the service, a non-regulated Tender process would be carried out. The TSH is governed by the National Procurement policies which provides assurance to the process of a SLA's.

**Please provide information on how these systems and processes, and their application, have improved outcomes for service users**

This should include, but not be limited to data in relation to patient safety and quality of care measures and outcomes, patient feedback and adverse event reporting; what this data has shown and any trends; and any actions taken as a result.

All external members of staff who provide a service within the organisation are invested by a security induction to ensure they remain and deliver safe practice in accordance with our policies and procedures. For those delivering a service directly to patients on a regular basis they will also be provided with PMVA or Breakaway training. This has enabled us to provide expert care to patients particularly in areas of Spiritual & Pastoral Care, Patient Advocacy Service, palliative care, Primary Care, Volunteers and language interpreters when we cannot provide this expertise from within our workforce. The volunteers provide a key role to those patients who have no family or friends in their life. The hospital also supports students in their learning from open university's, other hospitals and across many disciplines. These staff are supported within their specialism and asked to provide feedback on their learning experience. Feedback both formally and informally is positive.

**Areas of success, achievement or learning**

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

| Area of success / achievement / learning | Details | Further action |
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|---|---|---|
| This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. | This should describe the situation: what is the success, achievement or learning? For example, when procuring from private hospitals, the organisation has incorporated the requirements of the Act into the tender process. | This should describe how the success, achievement or learning could be used in the future. For example, the learning from tendering with private hospitals is now being used to implement arrangements in other types of procurement. |
| Nursing | The introduction of a Supplementary Staffing Register has enabled us to support staff work more flexibly. The register is made up of retire and return members of staff at Band 3 and Band 5 grade who are fully aware of their roles and responsibilities. We have also opened up this register to year 3 student nurses who are on placement with the option of remaining on the register after their placement ends. This was an additional support of filling shifts when we were unable to have a 'Bank' facility like other health boards. | To continue to develop the SSR and to have conversations to widen the membership. |
| Patient Engagement | Robust processes are in place regarding our annual review when we hear patient's feedback which includes the advocacy annual review. | Continue to promote patient engagement across various work streams |
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| | | |

**Areas of escalation, challenges or risks**

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

| Area of escalation / Challenge / Risk | Details | Action |
|---|---|---|
| This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. | This should describe the situation: what is the challenge or risk identified? For example, there may have been difficulties in planning or securing services from a particular speciality in relation to having regard to the need for that service to have appropriate staffing arrangements in place. | This should describe what actions have been / are being / will be taken to address the situation. For example, engaging with service providers to ensure that they understand what information is required, seeking alternative service providers etc. |
| International Recruitment | The TSH doesn't currently have a visa programme in place to allow international recruitment. Potential candidates must be established in the UK to apply for posts. | Discussions to change/update practice are in preliminary stages. Overseas applicants is currently being addressed nationally. |
| | | |
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| | | |
| | | |

**Declaration:** The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

**Level of Assurance:** Please indicate level of assurance provided

Substantial Assurance

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

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|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 16 |
| Sponsoring Director: | Director of Workforce |
| Author(s): | Director of Workforce |
| Title of Report: | Staff Governance Report |
| Purpose of Report: | For Noting |

## 1 SITUATION

This report provides an update on overall workforce performance to 31 March 2025.

Information and analysis is provided to the Workforce Governance Group, the Operational Management Team and Corporate Management Team. Information is also provided on a 6-weekly basis to the Partnership Forum.

## 2 BACKGROUND

The State Hospital use a dashboard system called Tableau. The Workforce Dashboards are available for access by Tableau users. The system has the ability for managers to set up subscriptions to reports on particular days so that they receive an auto-notification.

The Tableau dashboards are updated on a daily basis with attendance information using information from the SSTS system, meaning that the information available is live and as accurate and up to date as the information input by managers.

The information is provided to the end of March 2025, including the national figures for sickness absence for completion of the rolling year.

## 3 ASSESSMENT

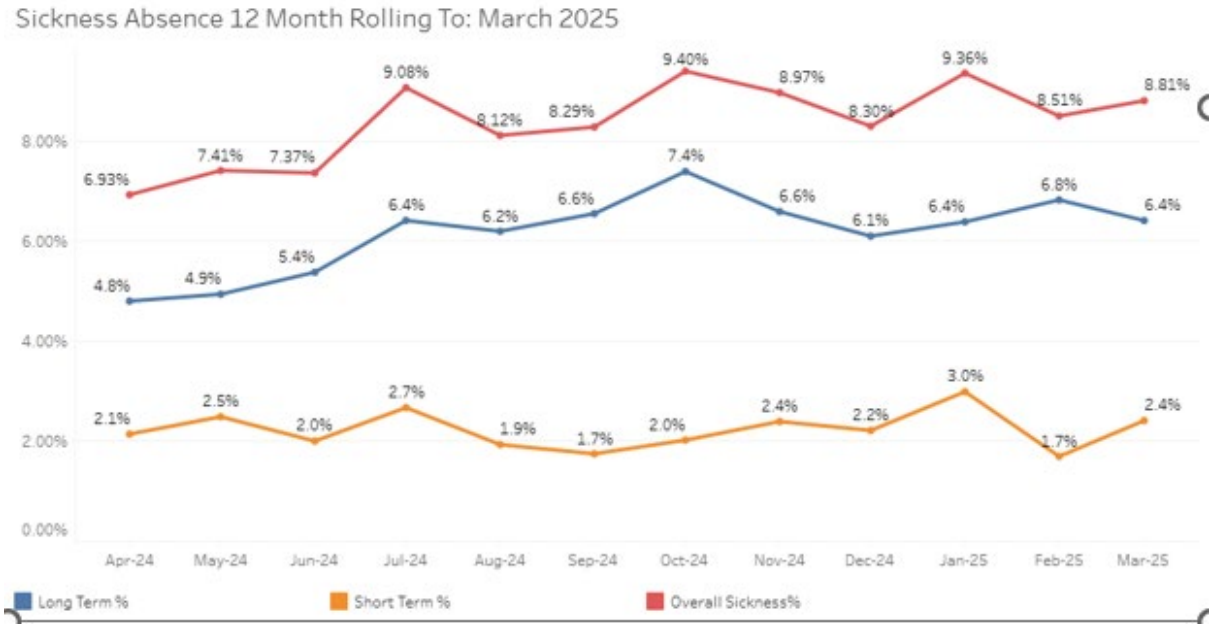
### (a) ATTENDANCE MANAGEMENT

#### TSH Sickness Absence (April 24 to March 25)

Sickness Absence remains a significant and ongoing challenge for TSH in ensuring sustained improvement.

In January 2025, sickness absence increased by over 1% Board wide as outlined in Graph 1 below:

**GRAPH 1**



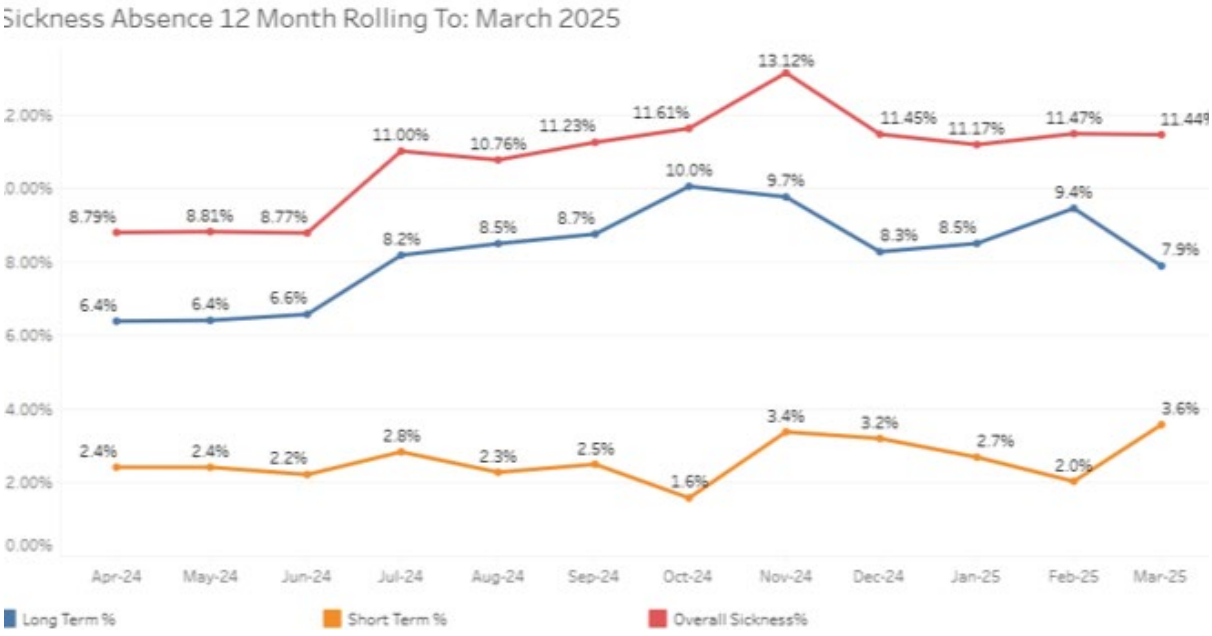

Absence for February has been confirmed as 8.51%, which highlights a projected small increase in March to 8.81%. A small drop in our long-term absence has been offset by a larger increase in short term absence.

However, our long-term absence at 6.4% remains greater than our target absence at 5%, which highlights the challenge of making sustained improvement.

### Nursing Sickness Absence (April 24 to Mar 25)

Nursing sickness remains the major challenge for TSH with Nursing reaching 11.44% for March. Nursing have seen a reduction in long term absence (although this remains higher than the Board average), but an increase in short term absence.

**GRAPH 2**



## ATTENDANCE MANAGEMENT OBSERVATIONS

| | | |
|---|---|---|
| **Patterns/Trends for TSH:** | Small increase in absence, with long term position remaining very challenging<br><br>Nursing has seen a smaller increase in month, but remains the area of greatest pressure (again with focus on long term absence 1 to 3 months) | |
| **Identified Departments of Concern:** | Skye Centre<br>Arran 1<br>Lewis 3<br>Mull 1 | 19.3%<br>18.09%<br>14.3%<br>14% |
| **Reasons:** | **Key reasons for long-term absence:**<br>Anxiety/Stress/depression/other psychiatric illnesses, Injury/fracture, other Musculoskeletal.<br><br>**Key reasons for short-term absence:**<br>Cold/ cough/ flu, Anxiety/Stress/depression/other psychiatric illnesses, injury fracture problems. | |
| **Activity:** | At the time of reporting, for the month of March:<br>- 18 staff were invited to a Stage 1 meeting<br>- 3 invited to a Stage 2 meeting<br>- 0 Stage 3 meeting was reconvened. | |
| **Benchmarking:** | Rowanbank<br>Orchard Clinic | 8.15%<br>15.39% |

## MAXIMISING ATTENDANCE – FUTURE ACTIONS

During the course of this year, we will review our approach to Maximising Attendance, recognising that the person centred, supportive approach to managing absence in line with the NHS Scotland policy. The key areas for improvement are:

- **Communication:** Whilst our approach to managing absence will be person centred and supportive, we need greater focus on the impact of absence and the challenge of sustaining this level of absence in the provision of our services. For example, based on current absence figures, Nursing staff are averaging 10 days per person more sickness per year than board colleagues or every nursing staff will have on average over 5 weeks sickness per year.

- **Impact and Sustainability**: Greater focus will be placed on these factors in future absence training

- **Manager Capability**: focus on the role of the manager in maximising attendance as part of broader Management Development Programme.

- **Continued review of pathways:** Ensuring staff are on the correct route, receiving the right support as quickly as possible.

- **Continued escalation management meetings:** Chaired by Head of Service/Lead Nurse and Head of HR, line managers with higher than targeted sickness absence are required to meet to review absence management and identify actions in detail.

- **Further analysis of long term absence patterns:** further analysis be undertaken to review employees who have had recurring long term absence to ensure that support, accommodations and adjustments in place are effective in maximising attendance at work

## (b) RECRUITMENT

Our Recruitment process continues to work proactively, with vacancies processed timeously to support services:

| | | |
|---|---|---|
| **TIME TO HIRE** | 89 days (KPI of 75 days) | KPI impacted by requirement to extend closing dates due to lack of suitable candidates |
| **VACANCIES ADVERTISED** | 8 posts were progressed during March, totalling 20 vacancies. This included posts to support the Women's Service. | |
| **SUMMARY OF NURSING VACANCIES:** | In March, there are 5.4 wte Band 5 Registered Nurse vacancies | |
| | 7.4wte Band 3 started on of 19th March as part of a Test of Change (as approved at December Board Meeting) | |

### SUPERNUMARY STAFFING

The month of January saw our reliance on supernumerary staff increase slightly across all areas, which is likely to be directly related to the increase in short term absence.

| | | |
|---|---|---|
| **OT & EXCESS** | 49.47 WTE | A decrease of 1.96 wte in month |
| **NURSING** | 31.00 WTE | A decrease of 0.64 WTE in month |
| **SSR** | 11.7 WTE | A decrease of under 0.5 WTE in month |

## (c) EMPLOYEE RELATIONS

### LIVE CASES

The table below provides a summary of current cases and timescales:-

- 1 new ER cases commenced in the month of March.
- The three cases in excess of 6 months have concluded in March/April and will be updated.

| **Ongoing ER Case Work** | | | | | |
|---|---|---|---|---|---|
| | <1 month | 1-3 months | 3-6 months | 6+ months | Total |
| **Capability - formal** | 0 | 0 | 0 | 0 | 0 |
| **Conduct - formal** | 1 | 0 | 6 | 3 | 10 |
| **Bullying & Harassment - formal** | 0 | 0 | 0 | 0 | 0 |
| **Grievance - formal** | 0 | 0 | 0 | 0 | 0 |
| **Whistleblowing** | 0 | 0 | 0 | 0 | 0 |

Focus continues to support early resolution where possible, minimise formal cases and also reduce timescales for all ER cases that are required to progress.

## (d) LEAVERS

**Leavers**

- There were 8 leavers in March 2025, (compared to 4 in February). YTD total is 58.
- Turnover YTD is 8.1%, and the late increase in leavers in March (has taken our turnover above this time last year (7.44%). Fixed term contracts ending aligned to the end of the financial year contributed to this.

## (e) JOB EVALUATION

***Progress***

- *No new Job Descriptions were received and one review was requested.*

***Status***

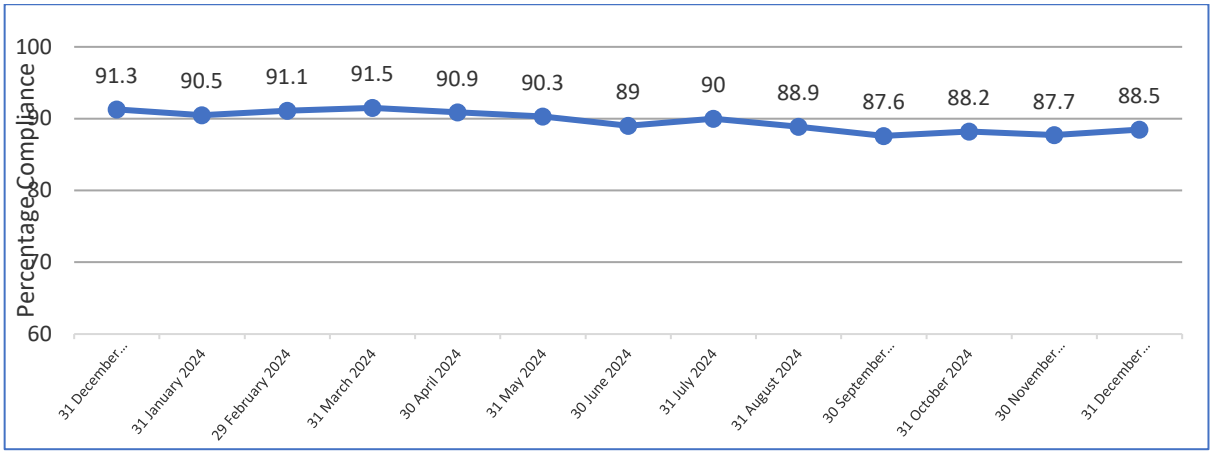
- *Quality Check panel arranged to complete the Review process.*
- *April JE panel dates and Quality Check dates are scheduled.*

***Job Evaluation Steering Group***

- *The group continue to meet bi-monthly taking forward any issues raised via the JE Practitioners involved in panels and quality checking.*

## (f) PDPR COMPLIANCE

PDPR also remains stable, with a small increase in month to 88.5%, remaining above the national target of 80%. Focus remains on maintaining compliance and improving the quality, impact and outcomes for TSH Staff.




## 4 RECOMMENDATION

The Board is invited to note the update on overall workforce performance.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy / LDP / Corporate Objectives** | N/A no proposal – update report<br>Supports delivery of Staff Governance Standards and Workforce Plan |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **4. Better Workforce**<br>d) Maximise workforce sustainability through delivery of the State Hospital's Recruitment and Retention Strategy, through modern, inclusive recruitment practice and continued development of a supplementary workforce.<br><br>l) Review and action absence related issues and prioritise support mechanisms and staff wellbeing to provide staff and line managers with the support required; and where absence is required, support staff to return to work at the earliest opportunity. Strengthen leadership and develop positive culture. |
| **Workforce Implications** | N/A |
| **Financial Implications** | N/A |
| **Route to Board**<br>Which groups were involved in contributing to the paper and recommendations. | Staff Governance, Partnership Forum, WGG and CMT |
| **Risk Assessment**<br>(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**<br>(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<br>X There are no privacy implications.<br>□ There are privacy implications, but full DPIA not needed<br>□ There are privacy implications , full DPIA included. |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 17 |
| Sponsoring Director: | Director of Workforce |
| Author(s): | Director of Workforce |
| Title of Report | Quarter 4 Update and Whistleblowing Annual Report |
| 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 2025 to 31 March 2025. No formal Whistleblowing cases were raised during this quarter either direct to The State Hospital or indirect via the INWO.

In the performance year 2024/25, the State Hospitals Board for Scotland had no cases raised under Whistleblowing.

This Annual Report details the work undertaken to review and re-establish our approach to implementation of the Standards within the Board, and our proactive approach to developing a supportive speak up culture.

## 4 RECOMMENDATION

The Board is invited to note the nil return for Quarter 4 of 2023/24 and the content of the Annual Whistleblowing Report, and endorse the annual report for the year.

**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. |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **4. Better Workforce**<br>n) Support the Independent National Whistleblowing Standards and support this workstream locally including promoting awareness for staff. Re-fresh local approach to delivery of standards, and collaborative working where possible. |
| **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**<br>Which groups were involved in contributing to the paper and recommendations. | Staff Governance Committee |
| **Risk Assessment**<br>(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**<br>(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<br>**X There are no privacy implications.**<br>□ There are privacy implications, but full DPIA not needed<br>□ There are privacy implications , full DPIA included. |

# THE STATE HOSPITALS BOARD FOR SCOTLAND

# WHISTLEBLOWING ANNUAL REPORT

# 1 April 2024 to 31 March 2025

## 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 fourth Annual Report and is for the reporting activity from 1 April 2024 until 31 March 2025.

The Executive Lead remains the Director of Workforce and this is a pragmatic decision reflecting the size of our organisation, which will continue to be reviewed.

## 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.

## 3. CONCERNS RAISED

Since 1 April 2024 to 31 March 2025 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 undertook a review of their approach to and implementation of the Whistleblowing Standards during the year 2024/25. Working closely with the Non Executive Whistleblowing Champion, we focused on a number of key areas:-

a) Re-establishing the role of Non Executive Whistleblowing Champion, with communication briefs in the run up to Speak Up week.
b) Raising general awareness of (i) the importance of Speaking Up and (ii) the Whistleblowing Process, which was largely completed in the lead up to, and over, Speak Up Week.
c) Ensure multiple routes are available to our staff who require support in any way, principally through our Wellbeing Centre.
d) Establish the independence and confidentiality of the Whistleblowing Process by ensuring the administration and governance of the process is managed through the Corporate Administration Team
e) Revised training and awareness for confidential Contacts, with up to date contact details provided on the intranet.
f) Setting up of a confidential Contact Forum quarterly with the Non Executive Whistleblowing Champion to provide support and establish any general trends.
g) Ensuring continued high compliance on Whistleblowing Standards Modules: 99% on General Awareness and 89% on Managers.
h) Provide additional training sessions on how to handle complaints or concerns from your staff.
i) As part of the Speak Up Week awareness, we highlighted the standards, the approach and importantly how to access support or to make a complaint under whistleblowing standards. We also provided reassurance over how such a concern would be handled

The State Hospital participated in the “Speak up Week” which took place from 30th September to 4th October 2024. Staff Bulletins were circulated to the service with updates from a number of contributors including the Chair, Chief Executive and Employee Director, including Speak Up Pledges from the Corporate Management Team.

A stall was in the reception area all week, with staff handing out key information and informing others of how the importance of Speak Up and how the Whistleblowing Process works

## 5. FUTURE ACTIONS

Work continues to improve our processes and means by which individuals can raise concerns, which include:

- Alignment of whistleblowing and Speak Up culture with our programmed OD activity during 2024/25, with a focus on culture and also on working environment, physically and psychologically.
- Continued awareness raising of the importance of Speaking Up and ensuring numerous routes to support this.
- Reviewing training and support for Confidential Contacts, including through national forums.

## 6. REPORTING

Reporting of any concerns raised through Whistleblowing is reported through Partnership, Workforce Governance Group, Corporate Management Team, Staff Governance and the Board.

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:

| | | |
|---|---|---|
| 25 April 2024 | - | Quarter 4 update for 1 January to 31 March 2024 |
| 22 August 2024 | - | Quarter 1 update, 1 March to 30 June 2024 |
| 19 December 2024 | - | Quarter 2 update, 1 July to 30 September 2024 |
| 27 February 2025 | - | Quarter 3 update, 1 October to 31 December 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

Whilst there were no formal cases raised via Whistleblowing in the past year, we have been able to fully review our approach to Whistleblowing and make positive improvements in this regard. This will also form a key part of our approach to Organisational Health, which will closely align to ‘Speak Up’and Whistleblowing, in terms of developing an environment where staff feel safe to raise their concerns in a safe and secure environment.

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

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|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 18 |
| Sponsoring Director: | Director of Workforce |
| Author(s): | Head of HR and Director of Workforce |
| Title of Report: | Protecting Vulnerable Groups: Update |
| Purpose of Report: | For Noting |

## 1 SITUATION

This report provides an update on changes being made by Disclosure Scotland with effect from 1 April 2025 relating to Protecting Vulnerable Groups Legislation and the implications for The State Hospital.

## 2 BACKGROUND

Under the Disclosure (Scotland) Act 2020, Disclosure Scotland have introduced a number of changes to current processes, which will impact on The State Hospital.
The key changes are summarized below:

- Protecting Vulnerable Groups (PVG) Scheme becomes a legal requirement
- Level 1 and Level 2 will replace the current 'Basic', 'Standard' and 'Enhanced' disclosure levels.
- Applicants will have the option to request an independent review of certain disclosure content and must provide their approval before Disclosure Scotland shares this information with the organisation. A 28-day window is granted for applicants to provide their approval.
- Applicants will be able to explain the context for certain spent convictions before they're disclosed.

Additionally, from 1 April 2025, PVG membership will be mandatory for all regulated roles with the definition of regulated having been updated.

*In Scotland, a 'regulated role' refers to a position, whether paid or voluntary, that involves performing specific activities where individuals have contact with children or protected adults. In a healthcare setting, examples of such roles may include;*

- *Jobs providing health care for children or protected adults.*
- *Staff or volunteers in hospitals or hospices providing cleaning, food preparation, caretaking or maintenance services that is provided for children or protected adults.*

## 3 ASSESSMENT

In response to these changes, and to meet the short timeframe, the Workforce Directorate have developed an activity timeline to implement these changes:-

| Activity | Completed by |
|---|---|
| Review all existing posts to determine if they require retrospective PVG | 18 April 2025 |
| Identify exact number of individuals who will require retrospective checks | 18 April 2025 |
| Arrange communication with affected staff and managers to confirm that they will require to complete a PVG | 18 April 2025 |
| Checks will be undertaken over a programmed period requiring:<br>(1) Identification Checks<br>(2) Completion of an email form which is started by the Workforce Team | Week commencing 28 April 2025, utilizing Occupational Health to allow staff to bring Identification documents with them. |
| Mop up exercise undertaken during the start of June | 13 June 2025 |
| Manage the return of Disclosure certificates, including clarification with staff side regarding the process for staff who are not given PVG membership or there is an undisclosed return. | 20 June 2025<br><br>(Management of the returned certificates is likely to extend over two to three months, depending on backlog with Disclosure Scotland). |

It is also important to consider:-

- We will require to process 200 to 250 new PVGs at an individual cost of £59, total cost of £12,000 to £15,000.
- In processing 200 to 250 PVGS, along with our annual average of 60 PVGS and alongside recruitment for the Women's Service will see an increase of 400% on our normal average.
- The management of the returned checks will also require administration and management/HR support for any responses which affect the person's suitability for employment.
- Whilst we have not yet factored the 5 yearly renewal into these calculations, subject to further national guidance, it would be our intention to spread this over 5 years to balance the workload for subsequent renewals. This will also amount to approximately 120 renewals per year (at associated cost circa £18 and resource implications for the Workforce Team).

As well as the direct impact of these changes in relation to additional disclosure checks, there is the potential for extended delays in 'normal' recruitment and onboarding if Disclosure Scotland are not adequately staffed to support the increase in PVG applications over the next two months. This could have implications for all recruitment including that for the Women's Service.

## 4 RECOMMENDATION

The Board is invited to note the content of this report and the proposed actions to meet our legal obligations in terms of Protecting Vulnerable Groups.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy /ADP** | Workforce Planning |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **4. Better Workforce**<br>d) Maximise workforce sustainability through delivery of the State Hospital's Recruitment and Retention Strategy, through modern, inclusive recruitment practice and continued development of a supplementary workforce.<br><br>i) Sustain a safe working environment for staff with a focus on risk management across all aspects of the organisation. |
| **Workforce Implications** | Implications in terms of:<br>- Volume of additional staff who require checks and potential ER issues which may result from current staff group<br>- Recruitment Timeline being extended if Disclosure Scotland are unable to process number of applications.<br>- Resource implications for workforce team to support |
| **Financial Implications** | Additional Cost for additional staff who require a check and ongoing cost for renewals every 5 years as outlined in the paper. |
| **Route to Board**<br>Which groups were involved in contributing to the paper and recommendations. | CMT |
| **Risk Assessment**<br>(Outline any significant risks and associated mitigation) | Risk in:<br>- Failing to meet the legislative timeline<br>- Potential delays in recruitment/onboarding, in particular the Women's Service at present<br>- ER challenges regarding returns or or non-disclosures |
| **Assessment of Impact on Stakeholder Experience** | Impact of legislation on existing staff will be considered throughout implementation |
| **Equality Impact Assessment** | N/a |
| **Fairer Scotland Duty**<br>(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;<br>☐ There are no privacy implications.<br>☐ There are privacy implications, but full DPIA not needed<br>☐ There are privacy implications, full DPIA included |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

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|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 19 |
| Sponsoring Director: | Chief Executive Officer |
| Author(s): | Head of Corporate Governance |
| Title of Report: | Health Board Collaboration and Leadership |
| Purpose of Report: | For Decision |

## 1 SITUATION

The content of this paper has been agreed nationally. NHS Board Chief Executives have agreed to submit this paper to their own Board at its next scheduled meeting.

This paper:

- sets the context for renewal and reform following the First Minister's statement on 27 January 2025
- briefs NHS Boards on the new governance arrangements with the establishment of the NHS Scotland Executive Group and wider efforts to support a more collaborative ethos in NHS Scotland
- describes the need for all NHS Boards to ensure a systematic approach to balancing local delivery with the need to contribute to meet the needs of larger populations – beyond their geographical boundaries – in the delivery of planned care

## 2 BACKGROUND

The First Minister's statement on Improving Public Services and NHS Renewal on 27 January 2025, emphasised the need for NHS Boards to work collaboratively to achieve the principles and aims that he set out: improved access to services; shifting the balance of care to the community; focus on innovation to improve access to; and delivery of care. The First Minister's statement reflected the shift sought in DL(2024)31: A renewed approach to population-based planning across NHS Scotland, which was published on 28 November 2024. The DL emphasises the need for service planning to align with the population size and be collaborative. It highlights a significant shift in planning, organising, delivering, and potentially funding services to meet Scotland's changing needs and ensure high-quality, sustainable services. NHS Boards will be required to collaborate across NHS Board boundaries – and with Scottish Government – to implement these principles, particularly through the annual delivery plan process.

NHS Board Chairs and Chief Executives received a letter on 7 February 2025 from the Director General Health and Social Care and Chief Executive of NHS Scotland (DGNHS) setting out expectations about collaboration. This letter reaffirmed the principles set out in DL(2024)31 with an expectation for increased collaboration between NHS Boards for to help improve the health and

wellbeing of the citizens and communities of Scotland and is aligned to the principles of co-operation and assistance as set out in section 12 (J) of the 1978 NHS Scotland Act.

This letter also aligns with the key priority deliverables set out in the First Minister's speech on 27 January 2025 which aims to improve access, reform and equity for the people of Scotland.

## 3 ASSESSMENT

### Governance Arrangements

Over the past year, steps have been taken to revise national governance arrangements. This is intended enhance collaborative working in recognition that the challenges facing the NHS and social care require a system-level leadership and corporate working across NHS Board boundaries.

In October 2024, the NHS Scotland Executive Group was established. It is co-chaired by the Director General Health and Social Care and Chief Executive of NHS Scotland and the Chair of Board Chief Executives Group. This newly formed group provides collective leadership in addressing key issues which require a national perspective. NHS Chairs received a briefing on the role of the Group on 5 November 2024.

NHS Boards are working to advance practical examples of building a more cohesive approach to the design and delivery of services on behalf of NHS Scotland. NHS Board Chief Executives undertook a successful two-day session on group development and digital innovation in September 2024 at the National Robotarium in Edinburgh. In relation to adoption of new digital developments and products it was agreed that the default position should be national development approach and local adoption. It was also recognised that this principle may well apply in a range of other planning matters.

### Renewal and Reform

Since the end of 2024, a small cohort of Board Chief Executives, on behalf of the wider NHS Board Chief Executives Group, have contributed to a weekly reform coordination group. This group also includes senior Scottish Government officials and was set-up to create early dialogue on the phasing of reform and renewal plans due to be published this year. NHS Board Chief Executives have welcomed this approach as it has enabled NHS representatives to meaningfully contribute to and influence the early approach on reform and renewal.

Representatives of the reform coordination group led on delivery of a joint Chief Executives/Executive Leads and Scottish Government session on NHS Renewal, held at COSLA on 18 February. This session explored the current position of the 3 'products' that are due to be published in the first half of 2025:

- Operational Improvement Plan (by the end March)
- Population Health Framework (Spring)
- Health and Social Care Service Reform Framework (pre summer Scottish Parliament recess)

These policy documents will provide the platform for the delivery of the First Minister's commitments. There is significant opportunity for NHS Board Chairs, Chief Executives and teams to contribute to this work, as well as partners, patients and communities themselves. It is important that NHS Boards contribute to the scrutiny of any proposals to ensure that the plans are deliverable.

In parallel to reform, there is renewed focus on wider public sector reform and efficiency and productivity with an onus on Chief Executives and NHS Boards to ensure that all opportunities for service efficiency and improvement are explored and delivered, whilst simultaneously progressing longer term reform. A paper will be presented to the NHS Scotland Executive Group on 6 March on

Business Services which will demonstrate opportunities available to NHS Boards to deliver transformation of business services and supporting systems.

**Improvements in Planned Care**

NHS Board Chief Executive representatives updated colleagues on weekly meetings they had contributed to which were convened and chaired by the First Minister, including the Cabinet Secretary for Health and Social Care and Scottish Government officials. This has resulted in the development of a National Planned Care Framework, which sets out a number of principles for achieving the necessary improvements in planned care.

The Framework seeks to create a balanced planned care system, ensuring all patients in Scotland have equal and timely access to care. It aims to maintain or improve care standards while balancing short-term and long-term actions on waiting lists. This draft framework was discussed and approved by the NHS Board Chief Executives Group on 19 February. It will now be subject to engagement with NHS Boards.

The National Planned Care Framework exemplifies new working methods, adhering to the principles of cooperation and assistance outlined in section 12(J) of the 1978 NHS Scotland Act. As we advance in planning, organising, delivering, and potentially funding services to meet Scotland's evolving needs and lay the groundwork for service transformation, the Director General Health and Social Care and Chief Executive of NHS Scotland is committed to reviewing and modifying the performance governance of individual Boards to reflect this new approach, emphasising collective accountability. This will be important as there will likely be a requirement to adopt a collaborative approach to delivery across other key areas of healthcare policy.

## 4 RECOMMENDATION

The State Hospitals Board is asked to note:

- the commitment set out by the First Minister to progress the renewal and reform of the NHS in Scotland, and associated requirement for the Board to seek assurance on delivery of these commitments.
- the evolution of the new governance arrangements which are intended to enable and foster stronger collective accountability whilst underpinning the strength of local accountability mechanisms.

The State Hospitals Board is asked to acknowledge and endorse:

- the duality of their role for the population/Board they serve as well as their contribution to population planning that will cross traditional Board boundaries and approves local implementation of this approach, consistent with DL(2024)31 and 12 (J) of the 1978 NHS Scotland Act
- the anticipated increased pace of change and requirement for regional and national collaboration in coming weeks and months as there is requirement to deliver the principles set out by the First Minister in his speech on 27 January, to deliver efficiencies and savings and to put into action the commitments set out in the three reform documents.

The State Hospitals Board is asked to note

- that in response to these changes, it is recognised that there is requirement to refresh the traditional approach to Board performance framework and indeed Executive personal objectives, which was referenced in Caroline Lamb’s letter of 7 February.

**Appendix:** Letter from Caroline Lamb, Chief Executive of NHSScotland and Director General for Health and Social Care to All NHS Chairs and NHS Chief Executives dated 7 February 2025.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy /ADP** | This content of this paper has been agreed nationally, with each NHS Board being asked to note and endorse the content. This is emerging issue and is Scottish Government directive. |
| **Corporate Objectives** | **3. Better Value**<br>d) Work collaboratively across public sector bodies to ensure that best value is achieved in service planning, design and delivery, including through National Board collaboration and the Anchors Strategy<br><br>j) Strengthen corporate governance to ensure transparency and clear direction, both within and external to the organisation in line with the Blueprint for Good Governance. |
| **Workforce Implications** | There are no specific impacts to note from the content of this paper. |
| **Financial Implications** | This does not present any proposals requiring funding. The context of the paper is collaboration, and the aim of better value for NHS Scotland as a whole. |
| **Route to Board**<br>Which groups were involved in contributing to the paper and recommendations. | This is nationally directed through Board Chief Executive Group. |
| **Risk Assessment**<br>(Outline any significant risks and associated mitigation) | There are no identifiable risks presented. |
| **Assessment of Impact on Stakeholder Experience** | The paper outlines the role of collaborative working, linking to NHSScotland quality aims driven by effectiveness and person centered approach. |
| **Equality Impact Assessment** | There is no requirement for this. |
| **Fairer Scotland Duty**<br>(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 issues arising in this respect. |
| **Data Protection Impact Assessment (DPIA) See IG 16.** | Tick One<br>✓ There are no privacy implications.<br>☐ There are privacy implications, but full DPIA not needed<br>☐ There are privacy implications, full DPIA included |

Director-General Health & Social Care and
Chief Executive NHS Scotland
Caroline Lamb

E: dghsc@gov.scot

Scottish Government
Riaghaltas na h-Alba

All NHS Chairs and NHS Chief Executives

7 February 2025

Dear Colleagues

Following the First Minister's recent keynote speech on improving public services, I am writing to seek your support in taking forward the programme of reform and renewal for our NHS. The NHS Chairs meetings and the advent of the NHS Scotland Executive Group has meant a fundamental shift in the way we come together and lead the NHS, but we need to increase the pace at which we are implementing the range of improvements across our system, in order to maximise the effectiveness and efficiency of services.

In taking forward the range of system reform and improvement work, it is important that we fully utilise the opportunities provided by working across boundaries – giving life to the statutory duties placed upon all NHS Boards to work collaboratively in delivering healthcare services. This duty is set out in Section 12J of the National Health Service (Scotland) Act 1978 and provides the foundation for ensuring equitable and effective healthcare delivery across Scotland.

As system leaders, you are required to ensure that your Boards actively engage in collaborative arrangements with other Health Boards. This includes sharing resources, expertise and services, where appropriate, to optimise patient outcomes and improve efficiency across the system. Such co-operation is critical to achieving the best possible care for our population, especially given the complex challenges we face in addressing health inequalities and meeting the demands on services.

Over the last year we have strengthened our approach to collaboration and co-operation with you, beginning with the publication of the Model Framework Document for NHS Boards in April 2024. This document outlines how we collaborate and co-operate and provides a structured approach for Boards, detailing our respective roles, responsibilities, and the nature of how Boards interact with the Scottish Government. It aimed to provide greater clarity on governance and accountability and sets out our commitment to fostering effective partnerships to deliver high-quality healthcare services across Scotland.

Our commitment to working together has been further strengthened with the establishment of the NHS Scotland Executive Group, which first met in October 2024. Its primary aim is to support the effective governance, planning and delivery of healthcare services across Scotland. The NHS Scotland Executive Group plays a central role in supporting national and



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regional planning initiatives, such as those outlined in the NHS Scotland Planning Framework.

The recent publication of the NHS Scotland Planning Director's Letter, in November 2024, provides additional guidance on population-based planning, once again highlighting the need for strengthened national and regional coordination. The DL emphasised the establishment of a Single Planning Framework to ensure coherence and alignment in service delivery, infrastructure investment, and workforce planning at national level. The NHS Scotland Planning and Delivery Board (NHSSPDB) will oversee and govern these efforts, ensuring that resources are deployed efficiently and equitably across all Health Boards.

At the regional level, the letter outlines the importance of collaboration between neighbouring Health Boards to develop strategies that address the specific needs of local populations. Regional planning groups are expected to drive innovation and adaptability, responding to the unique health dynamics within their areas whilst aligning with the broader NHS Scotland priorities. These planning efforts are integral to achieving the vision set out in the 2016 National Clinical Strategy and the Public Bodies (Joint Working) (Scotland) Act, which prioritise integration and partnership working across sectors.

I believe we have all of the foundations now in place to allow you to fulfil your roles, as NHS leaders, but also in how we come together as an NHS Scotland to meet the needs of patients and the expectations of our communities.

Moving forward, I intend to work with employers to enhance the Executive Management Appraisal System so that we can properly assess and record the impact of working across board and wider system boundaries. This will be incorporated into the guidance for the 2024/25 performance review and 2025/26 objective setting process, which the Chief People Officer will issue in late February / early March. Similarly, the appraisals of NHS Chairs will encompass how they are facilitating and supporting the level of cross boundary working that we all see as essential.

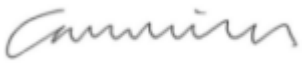
For now, I encourage you all to review your current arrangements for cross-boundary collaboration and identify any areas requiring improvement. Please also ensure that staff within your Boards are familiar with the statutory requirements of the Model Framework.

In the meantime, should you require clarification or support, please do not hesitate to contact my office.

Thank you for your continued leadership and dedication to delivering high-quality, patient-centred care for the people of Scotland.

Yours sincerely,

Caroline Lamb



Director General Health and Social Care and Chief Executive NHS Scotland



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**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 20(a) |
| Sponsoring Director: | Director of Finance and eHealth |
| Author(s): | Director of Finance and eHealth |
| Title of Report: | Annual Review of Standing Documentation |
| Purpose of Report: | For Decision |

## 1 SITUATION

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

## 2 BACKGROUND

The Board is required annually to approve the Standing Documentation i.e. Standing Financial Instructions, Scheme of Delegation and Standing Orders (covered under a separate Board paper). These were approved by the Audit and Risk Committee on 27 March 2025.

## 3 ASSESSMENT

### 3.1 Standing Financial Instructions

There are no amendments noted nor required. These were fully updated in 2022/23 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, and there are no further legal updates having effect currently.

### 3.2 Scheme of Delegation

There are no amendments noted nor required.

There remain some minor updates to deputising roles, which will be agreed between the Chief Executive and the Director of Finance and eHealth, as approved by the Audit and Risk Committee.

## 4 RECOMMENDATION

The Board is invited to agree the review of Standing Documentation.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy / ADP** | 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. |
| **Corporate Objectives** | **3. Better Value**<br>j) Strengthen corporate governance to ensure transparency and clear direction, both within and external to the organisation in line with the Blueprint for Good Governance. |
| **Workforce Implications** | None |
| **Financial Implications** | None |
| **Route to Committee**<br>Which groups were involved in contributing to the paper and recommendations. | Director of Finance and eHealth Director, Head of Procurement, Senior Financial Accountant |
| **Risk Assessment**<br>(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**<br>(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;<br>✓ **There are no privacy implications.**<br>☐ There are privacy implications, but full DPIA not needed<br>☐ There are privacy implications, full DPIA included |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**
**SCHEME OF DELEGATION**
VERSION 19 – MARCH 2025

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.<br>Detailed Scheme – No change<br>Financial limits<br>13.6 – Constraint text "subject to appointment of bankers by Board" removed<br>14.3 (d) – "Annually" added to Virement of Budget "per event over £25,000 and up to £100,000"<br>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.<br>Changes to responsibilities to reflect portfolio changes and changes in staff.<br>Financial limits amended to reflect limits in Pecos system<br>14.8 a) Capital value changed from £1.800 to £2,400<br>14.8 b) eHealth capital value added – value up to £4,000 and value up to £24,000<br>Approved by Audit Committee 24 April 2014. Approved by Board 26 June 2014. |
| 7 | April 15 | Amended PFPI to Equality & Involvement<br>Added Achievement of savings to 14.3 Management of Budgets<br>Changes to 16.1.3 re change in responsibility of patients' property.<br>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<br>Asset disposals 14.10 – removed Security Director limit up to £10k and replaced with Finance Director. Added 1uthorized deputy. |
| 8.1 | June 16 | Financial limit for waiver of tenders 14.9 increased from £3k to £5k.<br>Approved by Audit Committee and Board 23 June 2016. |

| Version | Date | Description |
|---|---|---|
| 9 | March 17 | Changed Nursing Director to Director of Nursing & AHP and removed reference to General Manager.<br>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.<br>Clinical Effectiveness Strategy 6.2 replaced with Quality Assurance and Improvement Strategy.<br>IM&T Security11.8 – change title of 2uthorized deputy to Information Governance and Data Security Officer.<br>Approved by Audit Committee 5 April 2018 |
| 11 | June 18 | Section 14.7 –-Pay Revenue Expenditure – Requisitioning / Ordering of Goods and Services<br>14.7c – change to >£15k - <£20k<br>14.7d – change to >£10k - <£15k<br>14.7e – change to >£5k - <£10k<br>14.7f – change to >£1k - <£5k<br>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<br>Section 8.1 – corrected delegated authority from Director of Nursing and AHPs to Medical Director<br>Approved by Audit Committee 28 March 2019 Approved by Board 20 June 2019 |
| 13 | March 2020 | Amended for updated job titles.<br>14.8 d) inclusion of Programme Director approval levels for contract variations.<br>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.<br>Amended terminology re Remobilisation Plan (formerly Annual Operating Plan)<br>Allocation of Risk responsibility to Security Directorate (section 5.2)<br>Approved by Audit Committee 25 March 2021<br>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.<br>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<br>Removed historic reference to sealing of documents Approved by Audit Committee 6 April 2023<br>Approved by Board 27 April 2023 |
| 18 | April 2024 | Insertion of new clause 14.1 re approval of expenditure in excess of SG annual allocation<br>Updated Director titles (Nursing & Operations, Workforce, Security Estates and Resilience)<br>Approved by Audit and Risk Committee 21 March 2024<br>Approved by Board 25 April 2024 |

| Version | Date | Description |
|---|---|---|
| 19 | March 2025 | For approval by Audit and Risk Committee 27 March 2025 |

## 1. DELEGATION OF POWERS

### 1.1 Delegation to Committees

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.

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

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.

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.

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.

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

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

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

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.

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.

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.

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 | Director of Finance & eHealth ("Finance Director") | N/A | CG & RM standards, SG standards, Governance Statement |
| **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

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **3.1 Preparation of Communications Strategy - Overall communications framework** | Chief Executive | Head of Communications | N/A | - |
| **3.1 Preparation of Communications Strategy - Internal (staff)** | Chief Executive | Head of Communications | N/A | SG Standards |
| **3.1 Preparation of Communications Strategy - External** | Chief Executive | Head of Communications | N/A | CG & RM Standards |
| **3.1 Preparation of Communications Strategy - 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<br>CG & RM standards |
| **4.2 Preparation of Corporate Objectives, Targets, Measures** | Chief Executive | Finance Director | as above | SGHSCD letter<br>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 |
| **5.2 Policies and Procedures -** Child Protection | Director of Nursing | N/A | N/A | - |
| **5.2 Policies and Procedures -** Prescribing | Associate Medical Director | N/A | N/A | HDL(2007)12 Safer management of controlled drugs<br>- Accountable Officer status delegated to Associate Medical Director |
| **5.2 Policies and Procedures -** 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<br>Research Governance Standards |
| **6.3 Research Governance -** 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 | Scottish Government approval is required for all claims in excess of £100,000 |
| 6.4 Legal Claims - Personal injury claims involving negligence where legal advice has been obtained and guidance applied | Finance Director | Chief Executive | < £25k | Scottish Government approval is required for all claims in excess of £100,000 |
| 6.4 Legal Claims - All other claims | Chief Executive | Finance Director | > £25k | Scottish Government approval is required for all claims in excess of £100,000 |
| 6.5 Complaints - Responding to complaints | Chief Executive | Deputy Chief Executive | N/A | Complaints guidance |
| 6.5 Complaints - 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<br>Equality & Involvement Self-Assessment |
| **7.2 Policies and Procedures - Equality/Diversity (Human Rights, Race, Disability, Gender, etc)** | Director of Nursing | N/A | N/A | CG & RM standards<br>Equality & Involvement Self-Assessment |
| 7.2 Policies and Procedures - Advocacy | Director of Nursing | N/A | N/A | CG & RM standards<br>Equality & Involvement Self-Assessment |
| 7.2 Policies and Procedures - Carers | Director of Nursing | Person Centred Improvement Lead | N/A | CG & RM standards<br>Equality & Involvement Self-Assessment |
| 7.2 Policies and Procedures - Volunteering | Director of Nursing | Person Centred Improvement Lead | N/A | CG & RM standards<br>Equality & Involvement Self-Assessment |
| 7.2 Policies and Procedures - Spiritual and Pastoral Care | Director of Nursing | Person Centred Improvement Lead | N/A | CG & RM standards<br>Equality & Involvement Self-Assessment |
| 7.2 Policies and Procedures - Patient and Carer Information and Communications | Director of Nursing | Person Centred Improvement Lead | N/A | CG & RM standards<br>Equality & Involvement Self-Assessment |

**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 |
| **8.1 Monitoring of Waiting Times** - 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 | N/A | SGHSCD guidance |
| **9.2 Compliance and adherence to national standards in cleaning** | Security Director | N/A | N/A | 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 Governance**

| 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<br>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<br>Information Governance Standards |
| **11.4 Data Protection Act - patient related data** | Caldicott Guardian | Head of eHealth | N/A | CG & RM Standards<br>Information Governance Standards |
| **11.4 Data Protection Act - staff related data** | Director of Workforce | Head of eHealth | N/A | CG & RM Standards<br>Information Governance Standards |
| **11.5 Freedom of Information Act** | Finance Director | Head of eHealth | N/A | CG & RM Standards<br>Information Governance Standards |
| **11.6 Caldicott Guardian** | Medical Director | Associate Medical Director | N/A | CG & RM Standards<br>Information Governance Standards |
| **11.7 Records Management - clinical records** | Caldicott Guardian | Health Records Manager | N/A | CG & RM Standards |
| **11.7 Records Management - 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<br>Information Governance Standards |

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **11.9 Data Quality** | Finance Director | Health Records Manager | N/A | CG & RM Standards<br>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 |
| **12.1 Staff Governance Standards** - HR policies and procedures | Director of Workforce | N/A | Within existing resources | PIN guidelines |
| **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 | GHSCD 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<br>Counter Fraud Service Partnership Agreement |
| **12.8 Disciplinary Action and Appeal**<br>a) Decision to dismiss | Any Director in consultation with Director of Workforce | N/A | N/A | - |

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **12.8 Disciplinary Action and Appeal** b) Appeal against disciplinary action short of dismissal | Manager of Disciplinary decision maker | N/A | N/A | Subject to no involvement in disciplinary action |
| **12.8 Disciplinary Action and Appeal** c) Appeal against disciplinary action short of dismissal (action taken by Director) | Chief Executive | N/A | N/A | - |
| **12.8 Disciplinary Action and Appeal** d) Appeal against disciplinary action short of dismissal (action taken by Chief Executive) | Staff Governance Committee | N/A | N/A | - |
| **12.8 Disciplinary Action and Appeal** e) Appeal against dismissal | Chief Executive | N/A | N/A | - |
| **12.8 Disciplinary Action and Appeal** f) Appeal against disciplinary action in respect of Directors | Remuneration Committee | N/A | N/A | - |
| **12.8 Disciplinary Action and Appeal** 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 |

| 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 | - |
| **12.8 Disciplinary Action and Appeal** b) Appeal against disciplinary action short of dismissal | Manager of Disciplinary decision maker | N/A | N/A | Subject to no involvement in disciplinary action |
| **12.8 Disciplinary Action and Appeal** c) Appeal against disciplinary action short of dismissal (action taken by Director) | Chief Executive | N/A | N/A | - |
| **12.8 Disciplinary Action and Appeal** d) Appeal against disciplinary action short of dismissal (action taken by Chief Executive) | Staff Governance Committee | N/A | N/A | - |
| **12.8 Disciplinary Action and Appeal** e) Appeal against dismissal | Chief Executive | N/A | N/A | - |
| **12.8 Disciplinary Action and Appeal** f) Appeal against disciplinary action in respect of Directors | Remuneration Committee | N/A | N/A | - |
| **12.8 Disciplinary Action and Appeal** 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 |
|---|---|---|---|---|
| **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 |
| **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 | £100k<br>£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**<br>Responsibility for keeping expenditure within budgets<br>a) at individual budget level (pay and non-pay) | Nominated budget-holders | Named Deputies | Budget notified | - |
| **14.4 Management of Budgets**<br>Responsibility for keeping expenditure within budgets<br>b) at service level | Directors | Named Deputies | Budget notified | - |
| **14.4 Management of Budgets**<br>Responsibility for keeping expenditure within budgets<br>c) for reserves and contingencies | Finance Director | Dep'y Director of Finance | - | - |
| **14.4 Management of Budgets**<br>Responsibility for keeping expenditure within budgets<br>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 |
|---|---|---|---|---|
| **14.4 Management of Budgets**<br>Responsibility for keeping expenditure within budgets<br>e) Virement of Budget between Directors - per event up to £25,000 | Directors | Named Deputies | < £25k | Subject to maximum virement limit of Chief Executive |
| **14.4 Management of Budgets**<br>Responsibility for keeping expenditure within budgets<br>e) Virement of Budget between Directors - per event over £25,000 and up to £100,000 annually | Chief Executive | Finance Director | > £25k < £100k | Subject to maximum virement limit of Chief Executive |
| **14.4 Management of Budgets**<br>Responsibility for keeping expenditure within budgets<br>f) Virement of Budget between Directors - non recurring | Finance Director | N/A | < £100k | Subject to maximum virement limit of Chief Executive |
| **14.4 Management of Budgets**<br>Responsibility for keeping expenditure within budgets<br>f) Virement of Budget between Directors - recurring | Chief Executive | N/A | < £100k | Subject to maximum virement limit of Chief Executive |
| **14.5 Engagement of staff not on establishment**<br>All staff (i.e. bank/agency/locums)<br>a) where aggregate commitment in any one year is less than £5,000 | Directors | Finance Director | < £5k | Subject to maximum virement limit of Chief Executive |
| **14.5 Engagement of staff not on establishment**<br>All staff (i.e. bank/agency/locums)<br>b) where aggregate commitment in any one year is more than £5,000 but less than £25,000 | Finance Director | Chief Executive | > £5k < £25k | Subject to maximum virement limit of Chief Executive |
| **14.5 Engagement of staff not on establishment**<br>All staff (i.e. bank/agency/locums)<br>c) where aggregate commitment in any one year is more than £25,000 | Chief Executive | N/A | > £25k | Subject to maximum virement limit of Chief Executive |

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **14.6 Setting of Fees and Charges** | Finance Director | N/A | N/A | - |
| **14.7 Agreement/ Licences**<br>a) Granting and termination of leases with annual rent less than £25,000 | Finance Director | N/A | < £25k | - |
| **14.7 Agreement/ Licences**<br>b) Granting and termination of leases with annual rent more than £25,000 | CE and FD jointly | N/A | > £25k | - |
| **14.7 Agreement/ Licences**<br>c) Preparation & signature of all tenancy licences for all staff subject to Board policy on accommodation | Finance Director | N/A | N/A | - |
| **14.7 Agreement/ Licences**<br>d) Extensions to existing leases | Chief Executive and Finance Director jointly | N/A | N/A | - |
| **14.7 Agreement/ Licences**<br>e) Letting of premises to outside organisations | Chief Executive | N/A | N/A | - |
| **14.7 Agreement/ Licences**<br>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**<br>a) Value over £100,000 | Board | N/A | >£100k | Subject to containment within overall Board resources |

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **14.8 Non-Pay Revenue Expenditure – Requisitioning / Ordering of Goods and Services** b) Annual Value over £20,000 and up to £100,000 | Chief Executive and Head of Procurement (PO only) | Finance Director, Deputy Chief Exec, Procurement Team Leader, Deputy Director of Finance, Finance Director (PO only) | >£20k < £100k | Subject to containment within overall Board resources |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** c) Annual Value over £15,000 and up to £20,000 | Finance Director and Head of Procurement (PO only) | Chief Exec, Deputy Chief Exec, Procurement Team Leader, Deputy Director of Finance, Finance Director (PO only) | >£15k < £20k | Subject to containment within overall Board resources |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** 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 |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** d) Annual Value over £10,000 and up to £15,000 | Head of Procurement (PO only) | Procurement Team Leader, Deputy Director of Finance, Finance Director (PO only) | >£10k < £15k | Subject to containment within overall delegated funds for Directorate |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** 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 |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** e) Annual Value over £5,000 and up to £10,000 | Head of Procurement (PO only) | Procurement Team Leader, Deputy Director of Finance (PO only) | >£5k < £10k | Subject to containment within overall delegated funds for Directorate |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** 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 |

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** f) Annual Value over £1,000 and up to £5,000 | Head of Procurement (PO only) | Procurement Team Leader (PO only) and Deputy Director of Finance (PO only) | >£1k < £5 | Subject to containment within overall delegated funds for Directorate |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** g) Annual Value up to £1,000 | Budget holder | Budget Manager | < £1k | Subject to containment within overall delegated funds for budget holder |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** g) Annual Value up to £1,000 | Head of Procurement (PO only) | Procurement Team Leader (PO only) and Deputy Director of Finance (PO only) | < £1k | Subject to containment within overall delegated funds for budget holder |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** 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 |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** i) Orders exceeding a 12-month period and up to £50,000 | Finance Director | Chief Executive | < £50k | Subject to containment within overall Board resources |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** j) Subsequent variations to contract | Finance Director | Chief Executive | N/A | Subject to containment within delegated limits and within budget |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** k) Specific exceptions to above limits – Utilities – up to £25,000 | Estates Manager | Estates Co-ordinator, Security Director | < £25k | Subject to containment within budget |

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** - k) Specific exceptions to above limits - Laundry - up to £5,000 | Estates Manager | Estates Co-ordinator | < £25k | - |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** k) Specific exceptions to above limits - - Decontamination – up to £3,000 | Estates Manager | Estates Co-ordinator | < £25k | - |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** k) Specific exceptions to above limits - Shop Trading Account – up to £5,000 | Designated budget holders | N/A | < £5k | Countersigned by Procurement Manager (PO only) |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** l) Consolidated orders up to £10,000 | Head of Procurement | Procurement Team Leader | < £10k | Subject to individual items authorised as above |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** 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 |
| **14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services** 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 |
| **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 |
| **14.9 Capital schemes** a) Non-IM&T capital schemes - approval and authorisation to proceed - 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 |

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **14.9 Capital schemes**<br>a) Non-IM&T capital schemes - approval and authorisation to proceed<br>- value up to £ 500,000 | Chief Executive | Deputy Chief Executive | < £0.5m | - |
| **14.9 Capital schemes**<br>a) Non-IM&T capital schemes - approval and authorisation to proceed<br>- value up to £ 10,000 | Finance Director | N/A | <£0.01m | - |
| **b) eHealth capital schemes - approval and authorisation to proceed**<br>-value over £ 1,000,000 | Board and SGHSCD jointly | N/A | > £1.0m | HDL (2005) 16 |
| **b) eHealth capital schemes - approval and authorisation to proceed**<br>- 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 |
| **b) eHealth capital schemes - approval and authorisation to proceed**<br>- value up to £100,000 | Chief Executive | Deputy Chief Executive | < £0.1m | - |
| **b) eHealth capital schemes - approval and authorisation to proceed**<br>- value up to £20,000 | Finance Director | N/A | N/A | - |
| **b) eHealth capital schemes - approval and authorisation to proceed**<br>- value up to £5,000 | Head of eHealth | N/A | N/A | Subject to containment within approved budget |
| **c) Selection of professional advisors** | Chief Executive | N/A | N/A | Subject to containment within approved budget |

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **d) Approval of variations to contract** -value up to £ 100,000 | Chief Executive | Deputy Chief Executive | > £25k < £100k | - |
| **d) Approval of variations to contract** - value up to £ 25,000 or 10% of approved expenditure of any scheme whichever is the lower | Security Director or Finance Director | N/A | < £25k | or 10% of approved spend whichever is lower |
| **d) Approval of variations to contract** - 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 |
| **d) Approval of variations to contract** value up to £ 1,000 on up to 5 occasions between contract Project Board meetings | Deputy Programme Director | N/A | < £1k | or 10% of approved spend whichever is lower |
| **14.10 Quotation, Tendering, Contract and 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 |
| **14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures** b) Tenders Regulated tender process over £ £50,000 and up to £100,000 | Finance Director | N/A | > £50k < £100k | Refer to Route 2 SG Procurement Journey Process |
| **14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures** b) Tenders Regulated tender process over £100,000 | Chief Executive | N/A | >£100k | Refer to Route 3 SG Procurement Journey Process if value over £138,760 (incl. Vat) |
| **14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures** c) Waiving of quotations & tenders over £10,000 | Chief Executive & Finance Director | N/A | N/A | - |

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures**<br>d) Arrangements for opening tenders | Head of Procurement | N/A | N/A | All Tenders are now electronic uploaded to PCS or PCS-T |
| **14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures**<br>e) Procurement Strategy Approval for Regulated Tenders<br>Contract value up to £250,000 | Director of Finance | N/A | N/A | Approval to proceed with tender process |
| **14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures**<br>e) Procurement Strategy Approval for Regulated Tenders<br>Contract value up to £250,000 Contract value over £250,000 | Chief Executive | N/A | N/A | Approval to proceed with tender process |
| **14.11 Condemning & Disposal of Assets (excluding heritable property)**<br>**Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively**<br>- with current /estimated purchase price up to £50,000 | Finance Director | Deputy Director of Finance | < £50k | - |
| **14.11 Condemning & Disposal of Assets (excluding heritable property)**<br>**Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively**<br>- with current/estimated purchase price over £50,000 | Chief Executive | N/A | > £50k | - |
| **14.12 Condemnations, Losses and Special Payments**<br>a) Compensation Payments made under legal obligation - ex gratia<br>- over £100,000 | Board | N/A | > £100k | Requires SGHSCD approval |

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **14.12 Condemnations, Losses and Special Payments**a)<br>a) Compensation Payments made under legal obligation - ex gratia - between £25,000 and £100,000 | Chief Executive | Deputy Chief Executive | >£25k < £100k | - |
| **14.12 Condemnations, Losses and Special Payments**<br>a) Compensation Payments made under legal obligation - ex gratia - up to £25,000 | Finance Director | N/A | < £25k | - |
| **14.12 Condemnations, Losses and Special Payments**<br>b) Other ex-gratia payments - other payments - over £5,000 | Board | N/A | > £ 5k | Requires SGHSCD approval |
| **14.12 Condemnations, Losses and Special Payments**<br>b) Other ex-gratia payments - other payments - up to £5,000 | Chief Executive | N/A | < £5k | - |
| **14.12 Condemnations, Losses and Special Payments**<br>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 |
| **14.12 Condemnations, Losses and Special Payments**<br>c) Stores/stock losses due to - theft, fraud, arson ; incidents of the service; or disclosed at check<br>- up to £20,000 | Finance Director & Chief Executive | N/A | < £20k | - |
| **14.12 Condemnations, Losses and Special Payments**<br>- d) Routine stores write on / write off disclosed at check - up to £100 | Deputy Director of Finance | N/A | < £100 | - |

| Area of Responsibility / Duties Delegated | Delegated To | Authorised Deputy | Financial Value £'m | Constraints/Reference |
|---|---|---|---|---|
| **14.12 Condemnations, Losses and Special Payments** d) Routine stores write on / write off disclosed at check - over £100 | Finance Director | N/A | > £100 | - |
| **14.12 Condemnations, Losses and Special Payments** e) Losses of cash due to theft, fraud, overpayment and others - over £5,000 | Board | N/A | > £5k | Requires SGHSCD approval |
| **14.12 Condemnations, Losses and Special Payments** e) Losses of cash due to theft, fraud, overpayment and others - up to £5,000 | Finance Director & Chief Executive | N/A | < £5k | - |
| **14.12 Condemnations, Losses and Special Payments** f) Abandoned Claims - over £5,000 | Board | N/A | > £5k | Requires SGHSCD approval |
| **14.12 Condemnations, Losses and Special Payments** f) Abandoned Claims - up to £5,000 | Finance Director & Chief Executive | N/A | < £5k | - |
| **14.12 Condemnations, Losses and Special Payments** g) Damage to buildings - over £20,000 | Board | N/A | > £20k | Requires SGHSCD approval |
| **4.12 Condemnations, Losses and Special Payments** g) Damage to buildings - up to £20,000 | Finance Director & Chief Executive | N/A | < £20k | - |

**DELEGATION TO INDIVIDUAL OFFICERS TO BE APPROVED BY FINANCE DIRECTOR**

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

**STANDING FINANCIAL INSTRUCTIONS**

VERSION 21

| 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.<br>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<br>Update for SGHD name change to SGHSCD<br>Update for revised CFS partnership agreement<br>Update for key procurement principles<br>Updated for staff title changes<br>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.<br>Approved by Audit Committee 24 April 2014.<br>Approved by Board 26 June 2014 |
| 11 | April 15 | Updated section 4.1.4 to include additional report.<br>Updated section 16.1.3 from Finance Director to Security Director.<br>Updated section 9.5.3 re authorisation of payroll change forms.<br>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.<br>Updated Section 4.1.4© to reflect changes in Annual Accounts reports.<br>Updated section 9.7 to reflect updated guidance from SG.<br>Approved by Audit Committee 24 March 2016. |
| 12.1 | June 16 | Amended section 10.3 re tender waiver limit from £3k to £5k.<br>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<br>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.<br>Updated section 3.6 to change Monitoring Returns to Financial Performance Returns.<br>Updated section 5 in relation to Project Bank Accounts.<br>Updated section 9.6 to reflect that payments to employees would be by bank credit only.<br>Updated section 13.1.1 to include reference to General Data Protection Regulations.<br>Updated section 16.1.10 to include new rules imposed in October 2017 around patient gambling.<br>Approved by Audit Committee 5 April 2018.<br>Approved by Board 28 June 2018 |
| 15 | March, May 2019 | Updated references to Local Delivery Plan – amended to Annual Operational Plan<br>Updated section 5.3.2 – reflect requirement of two directors' signed authorisation to open any bank account in the name of the Hospital<br>Removed section 17 – Funds held in Trust – no longer applicable to the Hospital with no endowment funds in place<br>Approved by Audit Committee 28 March 2019.<br>Approved by Board 20 June 2019 |
| 16 | March 2020 | Amended wording re secondment of HR Director (1.3.15)<br>Approved by Audit Committee 26 March 2020<br>Approved by Board 18 June 2020 |
| 17 | March 2021 | Updated references to Annual Operational Plan – amended to Remobilisation Plan<br>Updated job titles<br>Approved by Audit Committee 25 March 2021<br>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<br>Updated section 10.3.4,5 – update tender thresholds to comply with Procurement Act 2014, tender waiver from £5k to £10k (last update 2016)<br>Updated section 10.3.10 – re new TSH Procurement Policy<br>Updated section 10.4.1 – re new legislation<br>Approved by Audit Committee 17 March 2022<br>Approved by Board 23 June 2022 |
| 19 | March 2023 | Updated section 6.2.3 – updated job title<br>Approved by Audit Committee 6 April 2023<br>Approved by Board 27 April 2023 |
| 20 | April 2024 | References to Audit Committee amended to Audit and Risk Committee<br>Director titles updated (Workforce, Security Estates and Resilience, Nursing and Operations)<br>Updated section 6.4.9 – reflective of recommended practice<br>Approved by Audit and Risk Committee 21 March 2024<br>Approved by Board 25 April 2024 |
| 21 | March, April 2025 | For approval by Audit and Risk Committee 27 March 2025 |

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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 ("Finance Director") to:

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

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

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

## 1.2 Interpretation

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

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

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

## 1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

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

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

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

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

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

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

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

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

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

1.3.10 The Finance Director is responsible for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 3.2 Budgetary Delegation

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

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

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

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

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

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

### 3.3 Budgetary Control and Reporting

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

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

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

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

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

3.3.3 Each Budget Holder is responsible for ensuring that:

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

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

### 3.4 Cost Improvements and Income Generation

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

### 3.5 Capital Expenditure

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

### 3.6 Financial Performance Returns

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

## 4 ANNUAL ACCOUNTS AND REPORTS

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

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

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

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

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

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

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

4.1.5 The Board's audited annual accounts must be presented to a public meeting, not later than 6 months after the Board's accounting date. The audited annual accounts shall not be presented until the Audit 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 Finance Director is responsible for managing the Board's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by the SGHSCD.

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

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

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

### 5.2 Bank and GBS

5.2.1 The Finance Director is responsible for:

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

### 5.3 Banking Procedures

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

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

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

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

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

### 6.1 Income Systems

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

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

### 6.2 Fees and Charges

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

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

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

### 6.3 Debt Recovery

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

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

6.3.3 Overpayment when detected should be recovered.

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

### 6.4 Security of Cash, Cheques and Other Negotiable Instruments

6.4.1 The Finance Director is responsible for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 7.2 Asset Registers

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

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

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

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

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

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

### 7.3 Security of Assets

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

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

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

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

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

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

7.3.6 The Chief Executive is responsible for the maintenance of registers of assets, taking

account of the advice of the Finance Director concerning the form of any register and the method of updating.

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

7.3.8 Registers shall be maintained by the responsible officer for:

- Equipment on loan;
- Leased equipment.

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

### 7.4 Sale of Property, Plant and Equipment,

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

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

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

7.4.3 Managers must ensure that:

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

## 8 SERVICE LEVEL AGREEMENTS (SLAs)

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

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

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

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

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

## 9 TERMS OF SERVICE AND PAYMENT OF EXECUTIVE DIRECTORS AND EMPLOYEES

### 9.1 Remuneration and Terms of Service

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

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

9.1.3 The Remuneration Committee will:

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

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

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

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

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

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

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

### 9.2 Funded Establishment

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

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

## 9.3 Staff Appointments

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

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

## 9.6 Processing of Payroll

9.6.1 The Finance Director is responsible for:

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

9.6.2 The Finance Director will issue instructions regarding:

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

9.6.3 Appropriately nominated managers have delegated responsibility for:

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

## 9.7 Settlement Agreements, Early Retirement and Redundancy

9.7.1 The Director of Workforce, jointly with the Finance Director is responsible for:

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

### 9.8 Relocation Expenses

9.8.1 The 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 Finance Director will identify:

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

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

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

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

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

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

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

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

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

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

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

10.2.4 The Finance Director will:

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

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

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

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

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

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

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

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

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

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

10.2.6 Official Orders must:

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

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

a) All contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Finance Director in advance of any commitment being made
b) Contracts above specified thresholds are advertised and awarded in accordance with 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 Finance Director (and/or Chief Executive) on what action is to be taken

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

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

### 10.3 Tendering Procedures

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

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

a) The time scale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or
b) Specialist expertise is required and is available from only one source; or
c) The task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
d) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
e) The Product has been used within the hospital or other secure units and meets a security need. You must provide evidence of other similar products and the reason why these will not suit. (statement from 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 Finance Director it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive. Suppliers shall normally be chosen in rotation from the list unless the approval of the Chief Executive or nominated officer is given.

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

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

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

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

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

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

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

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

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

**10.4 Contracts**

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

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

**10.5 Grants and Similar Payments**

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

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

### 10.6 In-house Services

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

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

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

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

10.6.4 The evaluation group shall make recommendations to the Board.

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

## 11 STORES AND RECEIPT OF GOODS

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

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

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

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

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

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

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

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

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

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

## 12 RISK MANAGEMENT AND INSURANCE

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

12.1.2 The programme of risk management shall include:

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

12.1.3 The existence, integration and evaluation of the above elements will provide a basis for the Audit 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 Finance Director shall ensure that appropriate insurance arrangements exist in accordance with the risk management programme.

## 13 INFORMATION TECHNOLOGY

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

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

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

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

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

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

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

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

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

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

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

## 14 AUDIT

### 14.1 Audit 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 Finance Director to ensure that both an effective and cost effective internal audit service is provided. The Finance Director will retender Internal Audit services at least every five years. The Review panel will include the Chairman of the Audit and Risk Committee, the Chief Executive and the Finance Director 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 ("Finance Director")

14.2.1 The Finance Director is responsible for:

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

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

d) Developing and documenting an effective Fraud, Theft and Other Financial Irregularity Policy, and
e) Investigating cases of fraud, misappropriation or other irregularities, in consultation with the Chief Internal Auditor, Counter Fraud Service and the Police, where appropriate and shall notify the Chief Executive and Audit 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 Finance Director or designated auditors are entitled without necessarily giving prior notice to require and receive:

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

### 14.3 Internal Audit

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

14.3.2 Internal Audit will review, appraise and report upon:

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

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

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

14.3.4 The Chief Internal Auditor, or appointed representative, will normally attend Audit 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 Finance Director. The reporting and follow-up systems for internal audit shall be agreed between the Finance Director, 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 Finance Director shall maintain detailed procedures for the disposal of assets (excluding land) including condemnations, and ensure that these are notified to managers.

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

15.1.3 All unserviceable articles shall be:

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

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

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

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

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

| | No of Cases | £ | Delegated Limit |
|---|---|---|---|
| **Theft / Arson / Wilful Damage** | | | |

| | |
|---|---|
| Cash | 10,000 |
| Stores/procurement | 20,000 |
| Equipment | 10,000 |
| Contracts | 10,000 |
| Payroll | 10,000 |
| Buildings & Fixtures | 20,000 |
| Other | 10,000 |
| **Fraud, Embezzlement & other irregularities (inc. attempted fraud)** | |
| Cash | 10,000 |
| Stores/procurement | 20,000 |
| Equipment | 10,000 |
| Contracts | 10,000 |
| Payroll | 10,000 |
| Other | 10,000 |
| **Nugatory & Fruitless Payments** | 10,000 |
| **Claims Abandoned:** | |
| (a) Private Accommodation | 10,000 |
| (b) Road Traffic Acts | 20,000 |
| (c) Other | 10,000 |
| **Stores Losses:** | |
| Incidents of the Service | |
| - Fire | 20,000 |
| - Flood | 20,000 |
| - Accident | 20,000 |
| Deterioration in Store | 20,000 |
| Stocktaking Discrepancies | 20,000 |
| Other Causes | 20,000 |
| **Losses of Furniture & Equipment and Bedding & Linen in circulation:** | |
| Incidents of the Service – Fire | 10,000 |
| - Flood | 10,000 |
| - Accident | 10,000 |
| Disclosed at physical check | 10,000 |
| Other Causes | 10,000 |
| **Compensation Payments - legal obligation** | |
| Clinical | 250,000 |
| Non-clinical | 100,000 |
| **Ex-gratia payments:** | |
| Extra-contractual Payments | 10,000 |
| Compensation Payments - ex-gratia - Clinical | 250,000 |
| Compensation Payments - ex-gratia - Non Clinical | 100,000 |
| Compensation Payments - ex-gratia - Financial Loss | 25,000 |
| Other Payments | 2,500 |
| **Damage to Buildings and Fixtures:** | |
| Incidents of the Service – Fire | |
| - Fire | 20,000 |
| - Flood | 20,000 |
| - Accident | 20,000 |
| - Other Causes | 20,000 |
| **Extra-Statutory & Extra-regulationary Payments** | 0 |
| **Gifts in cash or kind** | 10,000 |
| **Other Losses** | 10,000 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.3.9 The Chief Executive has also the responsibility to designate an officer within the Board as Counter Fraud Champion. The role is a strategic one, and focuses on spearheading

change in culture and attitudes towards NHS fraud. Full background to this role is included within CEL 3 (2008). As such the role of Champion will complement the role of the Fraud Liaison Officer and includes responsibility for:

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

### 15.4 Remedial action

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

### 15.5 Reporting to the SGHSCD

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

### 15.6 Responses to Press Enquiries

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

### 15.7 Counter Fraud Services (CFS) – Access to Data

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

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

## 16 PATIENTS' PROPERTY

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

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

16.1.3 The 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 Finance Director.

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

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

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

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

### 18.2 Acceptance of Gifts and Hospitality

18.2.1 The acceptance of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Corruption Acts 1906 and 1916. In the event of a contractor or other supplier of goods or services making such an offer to any officer, either for their personal benefit or the "benefit" of the Board, the guidance given in HSG(93)5 and NHS Circular HDL (2003) 62 (or subsequent guidance issued by the Scottish Government Health and Social Care Department) must be followed. Initially, the matter must be reported to an individual's line manager, or the relevant Director. Acceptance, or refusal, of gifts or hospitality must be entered in a Register of Hospitality and Interests, which will be maintained by the Finance Director. The register will also record details of hospitality provided by the Board's employees:

a) Articles of a low intrinsic value, such as business diaries or calendars, need not be refused
b) Care should also be taken in accepting hospitality such as lunches and dinners, corporate hospitality events etc. All such offers should be reported to the officers line manager before accepting.
c) Visits at suppliers expense to inspect equipment etc should not be undertaken without the prior approval of the Chief Executive and in the case of the Chief Executive by the prior approval of the Chairman. Costs associated with such visits will be borne by The State Hospital.
d) If officers are involved in the acquisition of goods and services they should adhere to the ethical code of the Institute of Purchasing and Supply.
e) Officers should ensure that the acceptance of commercial sponsorship will not influence or jeopardise purchasing decisions.

### 18.3 Private Transactions

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

### 18.4 Declaration of Interest

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

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

and Interests.

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

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

| | |
|---|---|
| **Corporate Governance** | |
| **The Control Environment** | |
| Public Finance & Accountability (Scotland) Act 2000<br>HDL(2003)11 | Code of Corporate Governance |
| SSI(2001)301/2<br>MEL(1994)80 | Standing Orders |
| MEL(1994)80, Annex 4<br>MEL(1992)35 | Scheme of Reservation and Delegation |
| Appointed Officer Memorandum<br>SSI(2001) 301/2 | Accountable Officer Responsibilities |
| MEL(1994)80,<br>MEL(1996)42<br>HDL(2002)25, SGHD Audit Committee Handbook | Audit and Risk Committee |
| HDL(2002)11,<br>MEL(1996)42 | Internal Audit function |
| Section 2 of the National Health Service Reform (Scotland) Act 2004<br>HDL(2002)11 | Structures of assurance including CHPS |
| The Community Care (Joint Working etc.) (Scotland) Regulations 2002<br>CCD5/2005<br>CCD11/2002<br>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<br>HDL(2004)46 | Local Development Plan and regional planning |
| MEL(1994)15,<br>MEL(1999)14,<br>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,<br>MEL(1998)29,<br>MEL(2000)29,<br>HDL(2005)41 | Clinical Governance Committee |
| HIS Standards | Health Improvement Scotland Reports |
| **Staff Governance** | |
| HDL(2004)39,<br>HDL(2005)52<br>Staff Governance Standard | Staff Governance Committee |
| HDL(2006)54,<br>HDL(2006)23<br>HDL(2002)64,<br>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<br>NHS 1974(GEN)88 | Standing Financial Instructions |
| MEL(1994)48<br>Standards Commission | Standards of Business Conduct<br>Model Code of Conduct |
| HDL(2005)5<br>MEL(1994)48<br>RIPSA<br>CEL11(2013) | Fraud Theft & Corruption Policy and Response Plan |
| NHS 1974(GEN)88 | Budgetary control system |
| SI(94) No 468,<br>MEL(1994)80, Annex 9<br>HDL(2001)49 | Financial Procedures |
| MEL(1992)35 &59<br>,MEL(1998)9 | Acquisition, use, disposal and safeguarding of assets |

| | |
|---|---|
| MEL(1992)18<br><br>HDL(2002)87, MEL(1996)48, SCIM | Capital investment control and project management |
| MEL(1992)8<br>MEL(1992)9 | Property transactions procedures<br><br>Delegation of authority: land transactions |
| Annual Accounts Manual<br><br>Capital Accounting Manual<br><br>SPFM | Financial accounting and annual accounts presentation<br><br>Capital accounting policy and guidance<br><br>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<br>HDL(2005)46<br><br>NHSScotland eHealth Strategy Board guidance | IM&T strategy |
| HDL(2006)41<br><br>MEL(1992)14<br><br>MEL(1992)45<br><br>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: | 24 April 2025 |
| Agenda Reference: | Item No: 20(b) |
| 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 to conduct this review of standing documentation and then 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 Model Code of Conduct is based on the principles of Section 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000. The Code has been issued by Scottish Ministers, with the approval of the Scottish Parliament, as required by the Act. It is intended to set out the conduct expected of those who serve on Boards of public bodies in Scotland. When the State Hospital's Board first adopted this code, amendments were made to name it as the code of conduct for members of this Board specifically. At the same time the key principles were adopted. This was approved as the State Hospital's Members Code of Conduct.

It is proposed that the wording of the model code is adopted directly, to align with other public bodies including NHS Boards. This provides a clearer explanation of the duties and responsibilities of Board Members, as well as providing background on how the code should be interpreted and applied in practice.

A further change is to remove the following wording on training and development as this relates to matters of performance rather than conduct.

**“Training and Development of Members**

**The Chair 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 Audit and Risk Committee was in agreement with these changes and recommended that this proposal should be submitted to the Board.

## 4 RECOMMENDATION

The Board is asked to approve the review of the Standing Orders and proposed changes to the Members Code of Conduct as outlined.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy / ADP** | Ensures that the Board's standing orders and members code of conduct are up to date in respect of regulatory guidance. |
| **Corporate Objectives** | **3. Better Value**<br>j) Strengthen corporate governance to ensure transparency and clear direction, both within and external to the organisation in line with the Blueprint for Good Governance. |
| **Workforce Implications** | None identified as part of this reporting |
| **Financial Implications** | None identified as part of this reporting |
| **Route to Committee**<br>Which groups were involved in contributing to the paper and recommendations. | Required as part of annual review of standing documentation, and for onward recommendation to the Board. |
| **Risk Assessment**<br>(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**<br>(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<br>✓ **There are no privacy implications.**<br>□ There are privacy implications, but full DPIA not needed<br>□ 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.

**MODEL CODE OF CONDUCT**

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## Section 1: Introduction To The Model Code Of Conduct

1.1 This Code has been issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the Ethical Standards in Public Life etc. (Scotland) Act 2000 (the "Act").

1.2 The purpose of the Code is to set out the conduct expected of those who serve on the boards of public bodies in Scotland.

1.3 The Code has been developed in line with the nine key principles of public life in Scotland. The principles are listed in Section 2 and set out how the provisions of the Code should be interpreted and applied in practice.

### My Responsibilities

1.4 I understand that the 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. I will always seek to meet those expectations by ensuring that I conduct myself in accordance with the Code.

1.5 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all situations and at all times where I am acting as a board member of my public body, have referred to myself as a board member or could objectively be considered to be acting as a board member.

1.6 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all my dealings with the public, employees and fellow board members, whether formal or informal.

1.7 I understand that it is my personal responsibility to be familiar with the provisions of this Code and that I must also comply with the law and my public body's rules, standing orders and regulations. I will also ensure that I am familiar with any guidance or advice notes issued by the Standards Commission for Scotland ("Standards Commission") and my public body, and endeavour to take part in any training offered on the Code.

1.8 I will not, at any time, advocate or encourage any action contrary to this Code.

1.9 I understand that no written information, whether in the Code itself or the associated Guidance or Advice Notes issued by the Standards Commission, can provide for all circumstances. If I am uncertain about how the Code applies, I will seek advice from the Standards Officer of my public body, failing whom the Chair or Chief Executive of my public body. I note that I may also choose to seek external legal advice on how to interpret the provisions of the Code.

### Enforcement

1.10 Part 2 of the Act sets out the provisions for dealing with alleged breaches of the Code, including the sanctions that can be applied if the Standards Commission finds that there has been a breach of the Code. More information on how complaints are dealt with and the sanctions available can be found at **Annex A**.

## Section 2: Key Principles Of The Model Code Of Conduct

2.1 The Code has been based on the following key principles of public life. I will behave in accordance with these principles and understand that they should be used for guidance and interpreting the provisions in the Code.

2.2 I note that a breach of one or more of the key principles does not in itself amount to a breach of the Code. I note that, for a breach of the Code to be found, there must also be a contravention of one or more of the provisions in sections 3 to 6 inclusive of the Code.

The key principles are:

**Duty**
I have a duty to uphold the law and act in accordance with the law and the public trust placed in me. I have a duty to act in the interests of the public body of which I am a member and in accordance with the core functions and duties of that body.

**Selflessness**
I have a duty to take decisions solely in terms of public interest. Imust not act in order to gain financial or other material benefit for myself, family or friends.

**Integrity**
I must not place myself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence me in the performance of my duties.

**Objectivity**
I must make decisions solely on merit and in a way that is consistent with the functions of my public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

**Accountability and Stewardship**
I am accountable to the public for my decisions and actions. I have a duty to consider issues on their merits, taking account of the views of others and I must ensure that my public body uses its resources prudently and in accordance with the law.

**Openness**
I have a duty to be as open as possible about my decisions andactions, giving reasons for my decisions and restricting information only when the wider public interest clearly demands.

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

**Leadership**
I have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of my public body and its members in conducting public business.

**Respect**
I must respect all other board members and all employees of my public body and the role they play, treating them with courtesy at all times. Similarly, I must respect members of the public when performing my duties as a board member.

## Section 3: General Conduct

### Respect and Courtesy

3.1 I will treat everyone with courtesy and respect. This includes in person, in writing, at meetings, when I am online and when I am using social media.

3.2 I will not discriminate unlawfully on the basis of race, age, sex, sexual orientation, gender reassignment, disability, religion or belief, marital status or pregnancy/maternity; I will advance equality of opportunity and seek to foster good relations between different people.

3.3 I will not engage in any conduct that could amount to bullying or harassment (which includes sexual harassment). I accept that such conduct is completely unacceptable and will be considered to be a breach of this Code.

3.4 I accept that disrespect, bullying and harassment can be:

a) a one-off incident,
b) part of a cumulative course of conduct; or
c) a pattern of behaviour.

3.5 I understand that how, and in what context, I exhibit certain behaviours can be as important as what I communicate, given that disrespect, bullying and harassment can be physical, verbal and non-verbal conduct.

3.6 I accept that it is my responsibility to understand what constitutes bullying and harassment and I will utilise resources, including the Standards Commission's guidance and advice notes, my public body's policies and training material (where appropriate) to ensure that my knowledge and understanding is up to date.

3.7 Except where it is written into my role as Board member, and / or at the invitation of the Chief Executive, I will not become involved in operational management of my public body. I acknowledge and understand that operational management is the responsibility of the Chief Executive and Executive Team.

3.8 I will not undermine any individual employee or group of employees, or raise concerns about their performance, conduct or capability in public. I will raise any concerns I have on such matters in private with senior management as appropriate.

3.9 I will not take, or seek to take, unfair advantage of my position in my dealings with employees of my public body or bring any undue influence to bear on employees to take a certain action. I will not ask or direct employees to do something which I know, or should reasonably know, could compromise them or prevent them from undertaking their duties properly and appropriately.

3.10 I will respect and comply with rulings from the Chair during meetings of:

a) my public body, its committees; and
b) any outside organisations that I have been appointed or nominated to by my public body or on which I represent my public body.

3.11 I will respect the principle of collective decision-making and corporate responsibility. This means that once the Board has made a decision, I will support that decision, even if I did not agree with it or vote for it.

**Remuneration, Allowances and Expenses**

3.12 I will comply with the rules, and the policies of my public body, on the payment of remuneration, allowances and expenses.

**Gifts and Hospitality**

3.13 I understand that I may be offered gifts (including money raised via crowdfunding or sponsorship), hospitality, material benefits or services ("gift or hospitality") that may be reasonably regarded by a member of the public with knowledge of the relevant facts as placing me under an improper obligation or being capable of influencing my judgement.

3.14 I will never **ask for** or **seek** any gift or hospitality.

3.15 I will refuse any gift or hospitality, unless it is:

a) a minor item or token of modest intrinsic value offered on an infrequent basis;
b) a gift being offered to my public body;
c) hospitality which would reasonably be associated with my duties as a board member; or
d) hospitality which has been approved in advance by my public body.

3.16 I will consider whether there could be a reasonable perception that any gift or hospitality received by a person or body connected to me could or would influence my judgement.

3.17 I will not allow the promise of money or other financial advantage to induce me to act improperly in my role as a board member. I accept that the money or advantage (including any gift or hospitality) does not have to be given to me directly. The offer of monies or advantages to others, including community groups, may amount to bribery, if the intention is to induce me to improperly perform a function.

3.18 I will never accept any gift or hospitality from any individual or applicant who is awaiting a decision from, or seeking to do business with, my public body.

3.19 If I consider that declining an offer of a gift would cause offence, I will accept it and hand it over to my public body at the earliest possible opportunity and ask for it to be registered.

3.20 I will promptly advise my public body's Standards Officer if I am offered (but refuse) any gift or hospitality of any significant value and / or if I am offered any gift or hospitality from the same source on a repeated basis, so that my public

body can monitor this.

3.21 I will familiarise myself with the terms of the Bribery Act 2010, which provides for offences of bribing another person and offences relating to being bribed.

**Confidentiality**

3.22 I will not disclose confidential information or information which should reasonably be regarded as being of a confidential or private nature, without the express consent of a person or body authorised to give such consent, or unless required to do so by law. I note that if I cannot obtain such express consent, I should assume it is not given.

3.23 I accept that confidential information can include discussions, documents, and information which is not yet public or never intended to be public, and information deemed confidential by statute.

3.24 I will only use confidential information to undertake my duties as a board member. I will not use it in any way for personal advantage or to discredit my public body (even if my personal view is that the information should be publicly available).

3.25 I note that these confidentiality requirements do not apply to protected whistleblowing disclosures made to the prescribed persons and bodies as identified in statute.

**Use of Public Body Resources**

3.26 I will only use my public body's resources, including employee assistance, facilities, stationery and IT equipment, for carrying out duties on behalf of the public body, in accordance with its relevant policies.

3.27 I will not use, or in any way enable others to use, my public body's resources:

a) imprudently (without thinking about the implications or consequences);
b) unlawfully;
c) for any political activities or matters relating to these; or
d) improperly.

**Dealing with my Public Body and Preferential Treatment**

3.28 I will not use, or attempt to use, my position or influence as a board member to:

a) improperly confer on or secure for myself, or others, an advantage;
b) avoid a disadvantage for myself, or create a disadvantage for others or
c) improperly seek preferential treatment or access for myself or others.

3.29 I will avoid any action which could lead members of the public to believe that preferential treatment or access is being sought.

3.30 I will advise employees of any connection, as defined at Section 5, I may have to a matter, when seeking information or advice or responding to a request for information or advice from them.

## Appointments to Outside Organisations

3.31 If I am appointed, or nominated by my public body, as a member of another body or organisation, I will abide by the rules of conduct and will act in the best interests of that body or organisation while acting as a member of it. I will also continue to observe the rules of this Code when carrying out the duties of that body or organisation.

3.32 I accept that if I am a director or trustee (or equivalent) of a company or a charity, I will be responsible for identifying, and taking advice on, any conflicts of interest that may arise between the company or charity and my public body.

## Section 4: Registration Of Interests

4.1 The following paragraphs set out what I have to register when I am appointed and whenever my circumstances change. The register covers my current term of appointment.

4.2 I understand that regulations made by the Scottish Ministers describe the detail and timescale for registering interests; including a requirement that a board member must register their registrable interests within one month of becoming a board member, and register any changes to those interests within one month of those changes having occurred.

4.3 The interests which I am required to register are those set out in the following paragraphs. Other than as required by paragraph 4.23, I understand it is not necessary to register the interests of my spouse or cohabitee.

### Category One: Remuneration

4.4 I will register any work for which I receive, or expect to receive, payment. I have a registrable interest where I receive remuneration by virtue of being:

a) employed;
b) self-employed;
c) the holder of an office;
d) a director of an undertaking;
e) a partner in a firm;
f) appointed or nominated by my public body to another body; or
g) engaged in a trade, profession or vocation or any other work.

4.5 I understand that in relation to 4.4 above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of this specific public body does not have to be registered.

4.6 I understand that 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, “Other Roles”.

4.7 I must register any allowances I receive in relation to membership of any organisation under Category One.

4.8 When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

4.9 When registering remuneration from the categories listed in paragraph 4.4 (b) to (g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of my public body in terms of paragraph 6.7 of this Code.

4.10 Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

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

4.12 I understand that registration of a pension is not required as this falls outside the scope of the category.

**Category Two: Other Roles**

4.13 I will register any unremunerated directorships where the body in question is a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

4.14 I will register the registered name and registered number 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 I am a director and from which I receive remuneration.

**Category Three: Contracts**

4.15 I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in paragraph 4.19 below) have made a contract with my public body:

a) under which goods or services are to be provided, or works are to be executed; and
b) which has not been fully discharged.

4.16 I will register a description of the contract, including its duration, but excluding the value.

**Category Four: Election Expenses**

4.17 If I have been elected to my public body, then I will register a description of, and statement of, any assistance towards election expenses relating to election to my public body.

**Category Five: Houses, Land and Buildings**

4.18 I have a registrable interest where I 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 my public body.

4.19 I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of

the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to my public body and to the public, or could influence my actions, speeches or decision- making.

**Category Six: Interest in Shares and Securities**

4.20 I have a registerable interest where:

a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an interest in is greater than £25,000.

**Category Seven: Gifts and Hospitality**

4.21 I understand the requirements of paragraphs 3.13 to 3.21 regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

**Category Eight: Non–Financial Interests**

4.22 I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non- financial interests are those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by my public body).

**Category Nine: Close Family Members**

4.23 I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

**Section 5: Declaration Of Interests**

**Stage 1: Connection**

5.1 For each particular matter I am involved in as a board member, I will first consider whether I have a connection to that matter.

5.2 I understand that a connection is any link between the matter being considered and me, or a person or body I am associated with. This could be a family relationship or a social or professional contact.

5.3 A connection includes anything that I have registered as an interest.

5.4 A connection does not include being a member of a body to which I have been appointed or nominated by my public body as a representative of my public body, unless:

a) The matter being considered by my public body is quasi-judicial or regulatory; or
b) I have a personal conflict by reason of my actions, my connections or my legal obligations.

**Stage 2: Interest**

5.5 I understand my connection is an interest that requires to be declared where the objective test is met – that is where a member of the public with knowledge of the relevant facts would reasonably regard my connection to a particular matter as being so significant that it would be considered as being likely to influence the discussion or decision-making.

**Stage 3: Participation**

5.6 I will declare my interest as early as possible in meetings. I will not remain in the meeting nor participate in any way in those parts of meetings where I have declared an interest.

5.7 I will consider whether it is appropriate for transparency reasons to state publicly where I have a connection, which I do not consider amounts to an interest.

5.8 I note that I can apply to the Standards Commission and ask it to grant a dispensation to allow me to take part in the discussion and decision-making on a matter where I would otherwise have to declare an interest and withdraw (as a result of having a connection to the matter that would fall within the objective test). I note that such an application must be made in advance of any meetings where the dispensation is sought and that I cannot take part in any discussion or decision- making on the matter in question unless, and until, the application is granted.

5.9 I note that public confidence in a public body is damaged by the perception that decisions taken by that body are substantially influenced by factors other than the public interest. I will not accept a role or appointment if doing so means I will have to declare interests frequently at meetings in respect of my role as a board

member.  Similarly, if any appointment or nomination to another body would give rise to objective concern because of my existing personal involvement or affiliations, I will not accept the appointment or nomination.

## Section 6: Lobbying And Access

6.1 I understand that a wide range of people will seek access to me as a board member and will try to lobby me, including individuals, organisations and companies. I must distinguish between:

a) any role I have in dealing with enquiries from the public;
b) any community engagement where I am working with individuals and organisations to encourage their participation and involvement, and;
c) lobbying, which is where I am approached by any individual or organisation who is seeking to influence me for financial gain or advantage, particularly those who are seeking to do business with my public body (for example contracts/procurement).

6.2 In deciding whether, and if so how, to respond to such lobbying, I will always have regard to the objective test, which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard my conduct as being likely to influence my, or my public body's, decision-making role.

6.3 I will not, in relation to contact with any person or organisation that lobbies, do anything which contravenes this Code or any other relevant rule of my public body or any statutory provision.

6.4 I will not, in relation to contact with any person or organisation that lobbies, act in any way which could bring discredit upon my public body.

6.5 If I have concerns about the approach or methods used by any person or organisation in their contacts with me, I will seek the guidance of the Chair, Chief Executive or Standards Officer of my public body.

6.6 The public must be assured that no person or organisation will gain better access to, or treatment by, me as a result of employing a company or individual to lobby on a fee basis on their behalf. I will 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 I accord any other person or organisation who lobbies or approaches me. I will ensure that those lobbying on a fee basis on behalf of clients are not given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming.

6.7 Before taking any action as a result of being lobbied, I will seek to satisfy myself about the identity of the person or organisation that is lobbying and the motive for lobbying. I understand I may choose to act in response toa person or organisation lobbying on a fee basis on behalf of clients but it is important that I understand the basis on which I am being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code and the Lobbying (Scotland) Act 2016.

6.8 I will not accept any paid work:

a) which would involve me 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 my public body and its members. This does not prohibit me from being remunerated for activity which may arise because of, or relate to, membership of my public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

## Annex A: Breaches Of The Code

### Introduction

1. The Ethical Standards in Public Life etc. (Scotland) Act 2000 ("the Act") provided for a framework to encourage and, where necessary, enforce high ethical standards in public life.

2. The Act provided for the introduction of new codes of conduct for local authority councillors and members of relevant public bodies, imposing on councils and relevant public bodies a duty to help their members comply with the relevant code.

3. The Act and the subsequent Scottish Parliamentary Commissions and Commissioners etc. Act 2010 established the Standards Commission for Scotland ("Standards Commission") and the post of Commissioner for Ethical Standards in Public Life in Scotland ("ESC").

4. The Standards Commission and ESC are separate and independent, each with distinct functions. Complaints of breaches of a public body's Code of Conduct are investigated by the ESC and adjudicated upon by the Standards Commission.

5. The first Model Code of Conduct came into force in 2002. The Code has since been reviewed and re-issued in 2014. The 2021 Code has been issued by the Scottish Ministers following consultation, and with the approval of the Scottish Parliament, as required by the Act.

### Investigation of Complaints

6. The ESC is responsible for investigating complaints about members of devolved public bodies. It is not, however, mandatory to report a complaint about a potential breach of the Code to the ESC. It may be more appropriate in some circumstances for attempts to be made to resolve the matter informally at a local level.

7. On conclusion of the investigation, the ESC will send a report to the Standards Commission.

### Hearings

8. On receipt of a report from the ESC, the Standards Commission can choose to:

    - Do nothing;
    - Direct the ESC to carry out further investigations; or
    - Hold a Hearing.

9. Hearings are held (usually in public) to determine whether the member concerned has breached their public body's Code of Conduct. The Hearing Panel comprises of three members of the Standards Commission. The ESC will present evidence and/or make submissions at the Hearing about the investigation and any conclusions as to whether the member has contravened the Code. The member is entitled to attend or be represented at the Hearing and can also present evidence

and make submissions. Both parties can call witnesses. Once it has heard all the evidence and submissions, the Hearing Panel will make a determination about whether or not it is satisfied, on the balance of probabilities, that there has been a contravention of the Code by the member. If the Hearing Panel decides that a member has breached their public body's Code, it is obliged to impose a sanction.

**Sanctions**

10. The sanctions that can be imposed following a finding of a breach of the Code are as follows:

    - **Censure**: A censure is a formal record of the Standards Commission's severe and public disapproval of the member concerned.
    - **Suspension**: This can be a full or partial suspension (for up to one year). A full suspension means that the member is suspended from attending all meetings of the public body. Partial suspension means that the member is suspended from attending some of the meetings of the public body. The Commission can direct that any remuneration or allowance the member receives as a result of their membership of the public body be reduced or not paid during a period of suspension.
    - **Disqualification**: Disqualification means that the member is removed from membership of the body and disqualified (for a period not exceeding five years), from membership of the body. Where a member is also a member of another devolved public body (as defined in the Act), the Commission may also remove or disqualify that person in respect of that membership. Full details of the sanctions are set out in section 19 of the Act.

**Interim Suspensions**

11. Section 21 of the Act provides the Standards Commission with the power to impose an interim suspension on a member on receipt of an interim report from the ESC about an ongoing investigation. In making a decision about whether or not to impose an interim suspension, a Panel comprising of three Members of the Standards Commission will review the interim report and any representations received from the member and will consider whether it is satisfied:

    - That the further conduct of the ESC's investigation is likely to be prejudiced if such an action is not taken (for example if there are concerns that the member may try to interfere with evidence or witnesses); or
    - That it is otherwise in the public interest to take such a measure. A policy outlining how the Standards Commission makes any decision under Section 21 and the procedures it will follow in doing so, should any such a report be received from the ESC can be found here.

12. The decision to impose an interim suspension is not, and should not be seen as, a finding on the merits of any complaint or the validity of any allegations against a member of a devolved public body, nor should it be viewed as a disciplinary measure.

## Annex B: Definitions

**“Bullying”** is inappropriate and unwelcome behaviour which is offensive and intimidating, and which makes an individual or group feel undermined, humiliated or insulted.

**"Chair"** includes Board Convener or any other individual discharging a similar function to that of a Chair or Convener under alternative decision-making structures.

**“Code”** is the code of conduct for members of your devolved public body, which is based on the Model Code of Conduct for members of devolved public bodies in Scotland.

**"Cohabitee"** includes any person who is living with you in a relationship similar to that of a partner, civil partner, or spouse.

**“Confidential Information”** includes:

- any information passed on to the public body by a Government department (even if it is not clearly marked as confidential) which does not allow the disclosure of that information to the public;
- information of which the law prohibits disclosure (under statute or by the order of a Court);
- any legal advice provided to the public body; or
- any other information which would reasonably be considered a breach of confidence should it be made public.

**"Election expenses"** means expenses incurred, whether before, during or after the election, on account of, or in respect of, the conduct or management of the election.

**“Employee**” includes individuals employed:

- directly by the public body;
- as contractors by the public body, or
- by a contractor to work on the public body’s premises.

**“Gifts”** a gift can include any item or service received free of charge, or which may be offered or promised at a discounted rate or on terms not available to the general public. Gifts include benefits such as relief from indebtedness, loan concessions, or provision of property, services or facilities at a cost below that generally charged to members of the public. It can also include gifts received directly or gifts received by any company in which the recipient holds a controlling interest in, or by a partnership of which the recipient is a partner.

**“Harassment”** is any unwelcome behaviour or conduct which makes someone feel offended, humiliated, intimidated, frightened and / or uncomfortable. Harassment can be experienced directly or indirectly and can occur as an isolated incident or as a course of persistent behaviour.

**“Hospitality”** includes the offer or promise of food, drink, accommodation, entertainment or the opportunity to attend any cultural or sporting event on terms not available to the general public.

**“Relevant Date”** Where a board member had an interest in shares at the date on which the member was appointed as a member, the relevant date is – (a) that date; and (b) the 5th April immediately following that date and in each succeeding year, where the interest is retained on that 5th April.

**“Public body”** means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

**“Remuneration"** includes any salary, wage, share of profits, fee, other monetary benefit or benefit in kind.

**“Securities”** a security is a certificate or other financial instrument that has monetary value and can be traded. Securities includes equity and debt securities, such as stocks bonds and debentures.

**“Undertaking”** means:

a) a body corporate or partnership; or

b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 21 |
| Sponsoring Director: | Chief Executive Officer |
| Author(s): | Head of Corporate Governance |
| Title of Report: | Board Improvement Plan |
| Purpose of Report: | For Noting |

## 1 SITUATION

The NHSScotland Blueprint for Good Governance outlines a model for effective corporate governance to deliver good governance in healthcare. 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.

## 2 BACKGROUND

Along with all other NHS Boards, the State Hospital (TSH) completed a self-assessment questionnaire in 2023, which focused on effectiveness against the Blueprint model. The outcome of this exercise informed the creation of a Board Improvement Plan, which was then approved by the Board at its meeting on 25 April 2024 and submitted to Scottish Government. This reflected a positive position for the Board, with recognition of key areas of strength especially on setting the direction, leadership of strategic plans, monitoring of performance and scrutiny of evidence. The plan is attached as **Appendix A**.

The Board agreed that the plan should be reviewed at six monthly intervals, to monitor its implementation and subsequent impacts. At its meeting in October 2024, the Board noted the progress made in the following areas, and agreed further work should be take forward as highlighted below.

**Risk Management**
The Board is seeking a more streamlined position on the linkage of risk with performance and governance.

**Engaging Stakeholders**
To develop a stakeholder map, defining stakeholder groups and how TSH engages is different forums.

**Influencing Culture**
To raise awareness of the whistleblowing standards, supporting staff to feel confident about speaking up.

The Board has also recognised the more wide-ranging work led through Organisational Development (OD) focusing on the areas that matter to employees of the organisation and to target specific development approaches.

**Diversity, Skills, and Experience**
The plan focuses on succession planning as a key area of risk, and the need to take steps to build resilience.

**The Assurance Framework**
At its meeting in October 2024, the Board were content to note the wide range of workstreams in place including benchmarking TSH to other forensic settings within NHS Scotland, and to the three high secure hospitals within NHS England. Further, with the NHS England Clinical Secure Practice Forum and the NHS England High Secure Collaborative. There were no further suggested actions to take forward in this respect.

**Evaluation**
The plan set out the intention to promote the work of TSH both with the wider public and through collaborative workstreams. At its meeting in October 2024, the Board noted the range of collaborative work through NHS Scotland leadership groups, as well as a range of Service Level Agreements. Further, continued close working with the Forensic Network, and increased focus on relationships with external agencies. Additionally, the Board were assured by the way in which the Communications Strategy supports public awareness and is active in promoting TSH as an employer of choice. There were no further suggested actions to take forward in this respect.

## 3 ASSESSMENT

**Risk Management**
This is to be developed further as part of the improvement plan, linking the Corporate Risk Register to the Corporate Objectives. The Risk Team is working with each directorate to review their existing risks, and this has been completed for 80% of all risk across directorates. Further work is being progressed in this regard on the measurement of risk, and the adaptation of metrics to enable consistency of data to accurately measure presenting risks. A further update will return to the Board on the completion of this work.

The Tactical Risk, Resilience and Operational Security Group is being established as a subgroup of the Corporate Management Team (CMT). The Terms of Reference for the group has been developed and will include membership of clinical colleagues through the Senior Leadership Teams (SLTs). The aim is to provide SLTs leaders with a monthly overview and analysis, to help to identify any upcoming risks as well as to consider adjustment of service provision to align to risk reduction. It is intended that this group will be fully established by May 2025.

**Stakeholder Engagement:**
Plans are in place for a meeting late April/May to review the development of a Stakeholder Map and Model, which will identify their required engagement along with their interdependencies and links to other groups/workstreams.

In general terms, work is ongoing across a number of other workstreams in relation to engagement, specifically:

- Following on from the Medium-Term Plan, there has been broad engagement to support the development of the Board's Workforce Plan for 2025/28

- In terms of staff, there have been extensive engagements across a number of workstreams, specifically Organisational Development, Equality and Diversity and Shift patterns for Nursing staff.
- There has been engagement work with local schools and colleges encouraging the consideration of the diverse career option available within the board.
- Planning also to engage with local school regarding child friendly materials and processes being introduced.
- Practice improvement and clinical staff also attended a number of recruitment fairs.
- Following a very successful open day in May last year, TSH held a further two events in March 25. Plans are to continue to build on this approach.

**Influencing Culture**
The Board has reviewed its approach to Whistleblowing over the past 12 months. This was detailed in reporting to the February Board Meeting by the Non-Executive Whistleblowing Champion who submitted this to the Cabinet Secretary for Health and Social Care. This included the work progressed to build a culture of openness and transparency linked to the refreshed OD approach. Further, change to the processes and the management of Whistleblowing to establish a clear separation between whistleblowing concerns and 'Business as Usual' policy and processes. Additionally, this also captured the ongoing work to capture staff views on whistleblowing and more generally their working environment and wellbeing.

A comprehensive OD strategy is under creation using the OD cycle, enabling analysis of the current state of organisational health at TSH and providing key data on the priorities arising from this.
A three-year strategy document has been developed to outline this approach, and to detail how this challenge will be over the course of the next three years. The three priorities identified are the working environment, direction, and leadership and management. Wellbeing will be central throughout to this approach, aligned to these priorities.
This will represent a shift in focus for the organisation. Previously, the focus was concentrated predominantly on a reactive service, and the new aim to is to transition to a more preventative service that examines wider organisational health at the individual, team, and organisational levels. This will be presented to the Staff Governance Committee at its next meeting on 15 May 2025.

**Diversity, Skills, and Experience**
The Board Improvement Plan focuses on succession planning as a key area of risk, and the need to take steps to build resilience. A key area is the need for tailored internal approaches to be reviewed for senior specialised roles. TSH is an active part of the Senior and Executive National approach to Succession Planning and is currently reviewing the most appropriate approaches to support Succession Planning in Head of Service, and high risk identified areas, in the first instance. With the fast-paced approach to the implementation of the interim High Secure Women's Service, this is planned to take place during Quarter 3 of the current financial year.

The Non-Executive membership of the Board has been stable, with the re-appointment of members this year. However, a vacancy will arise in the next 18 months and the skills matrix for the Non-Executive Cohort will be reviewed in preparation for this. TSH participated in the Aspiring Chairs programme both as a Host Board, and in supporting individual participation last year, and will be participating as a Host Board again this year.

## 4 RECOMMENDATION

The Board is asked to note progress to date and provide any further input if required to the current plan.

Further to note that the expectation that guidance will be received through NHS Education for Scotland on the timing of the next self-assessment exercise for all NHS Boards.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy /ADP** | This supports the Board's approach to assurance, based on self-assurance exercise and development of plan for improvement across key identified areas. |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **3. Better Value**<br>j) 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**<br>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**<br>(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**<br>(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<br>X There are no privacy implications.<br>☐ There are privacy implications, but full DPIA not needed<br>☐ There are privacy implications, full DPIA included |

**Appendix A**

| Priority Area | Blueprint Function | High level Action | Interdependency | Lead | Timeline | Status |
|---|---|---|---|---|---|---|
| **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. |
| **Functions** | Engaging Stakeholders | Produce a stakeholder map to define who our stakeholders and the purpose of our engagement.<br>Review our Anchor strategy as a mechanism to develop community engagement and help with visibility and impact. | External agencies e.g. MWC, patients and carer groups, government, elected representatives and wider public | Director of Nursing and Operations/Head of Planning, Performance & Quality/OD | Feb-25 | This is new workstream - stakeholder map leads to be agreed then developed, building on existing workstreams. Anchor Plan agreed and baseline metrics in place. |
| **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 respond 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 support. |

| Priority Area | Blueprint Function | High level Action | Interdependency | Lead | Timeline | Status |
|---|---|---|---|---|---|---|
| **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 plan to be developed. |
| **Delivery** | The Assurance Framework | Explore further benchmarking opportunities and tools, keeping the Board updated. | NHS England High Secure , Forensic Network, | All Directors through CMT | Oct-24 | Covers range of areas and underway across directorates- single lead to be agreed for more coherence: eg .attendance management, digital inclusion, security , complaints , HR policy implementation etc |
| **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 custody, forensic network , information governance , PMVA techniques |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 22 |
| Sponsoring Director: | Chief Executive Officer |
| Author(s): | Head of Communications |
| Title of Report: | Communications Annual Report 2024/25 |
| Purpose of Report: | For Noting |

## 1. SITUATION

The Head of Communications is required to produce a Communications Annual Report covering performance from 1 April 2024 to 31 March 2025 in support of the Communications Strategy.

## 2. BACKGROUND

All communications activity supports the Board in the delivery of its core objectives and legal obligations. The establishment of a Communications Annual Report is therefore an important assurance process in considering the effectiveness of State Hospital internal and external communications.

## 3. ASSESSMENT

The Communications Service performed to a high standard, delivering a wide ranging and comprehensive communications service to stakeholders.

Updates on staffing, performance, and service delivery are all captured in the annual report.

There are no areas of concern.

## 4. RECOMMENDATION

The Board is asked to note the Communications Annual Report 2024/25.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy /ADP** | The Annual Report supports the State Hospital's Communications Strategy. The strategy supports legal obligations, local and national strategic objectives, quality assurance and quality improvement objectives, NHS values and behaviours, openness and transparency, professional standards, and best practice in PR and Communications. |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | The Communications Service supports all four corporate objectives equally. |
| **Workforce Implications** | Service delivery is dependent on the Service being at full establishment. |
| **Financial Implications** | While the decision to revise the full-time Band 5 vacancy to a part-time Band 4 post supports financial sustainability, it inevitably affects the team's ability to maintain current service levels and limits potential for future growth. |
| **Route to Board**<br>Which groups were involved in contributing to the paper and recommendations. | Sponsorship and governance route: Head of Communications and the Chief Executive. |
| **Risk Assessment**<br>(Outline any significant risks and associated mitigation) | As above for financial implications. The decision was influenced by financial considerations. While not without impact, it was necessary to ensure we remain within budget and can support longer-term resilience and succession planning. |
| **Assessment of Impact on Stakeholder Experience** | Promoting key messages and a positive image of the Hospital leads to improved public understanding of the State Hospital, mental illness, and helps to tackle associated stigma. |
| **Equality Impact Assessment** | Numerous EQIAs are in place to support the Communications Strategy and associated activity. |
| **Fairer Scotland Duty**<br>(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 Head of Communications works closely with the PCIS to support an inclusive approach to ensuring patients who experience significant barriers to communication are enabled to contribute meaningfully to all aspects of care and treatment. |
| **Data Protection Impact Assessment (DPIA) See IG 16.** | Tick One<br>□ There are no privacy implications.<br>□ There are privacy implications, but full DPIA not needed<br>☑ There are privacy implications, full DPIA included.<br><br>Numerous DPIAs are in place to support the Communications Strategy and associated activity. |

# COMMUNICATIONS SERVICE ANNUAL REPORT 2024/25

## 'ENABLING RESILIENCE AND GROWTH'

## 1. CORE PURPOSE

Communication is at the heart of everything we do. Within the State Hospital, the core purpose relates to all aspects of communications both internally and externally – from consultancy / advice and guidance to the provision of electronic communications, audio-visual production including video, dealing with the media, social media, the production of corporate publications, and stakeholder engagement. Specifically, the Head of Communications acts as a communications link between the Hospital and stakeholders including staff, the local community, general public, professional bodies, and local and national government, and drives forward improvements in communication. This enables the influencing and shaping of communication planning and strategy at all levels, ensuring good communications practice is firmly embedded in everyday service development, delivery, and change.

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Patients' Advocacy Service, and staff. Carers, the public and the media are included within external communication arrangements, which differs from the Communications function of other Boards. The State Hospital's public (patients) are with us for an average of 6.5 years, and some very much longer, and therefore are classed as internal stakeholders. The public are potential patients of territorial Boards and are viewed by them as external stakeholders. These Boards will therefore undertake direct engagement with their public in relation to health, wellbeing and services provided.

The two services predominately delivering internal and external communications within the State Hospital are the Communications Service and the Person Centred Improvement Service (PCIS). These two services work very closely together with the PCIS having specific responsibility for patient, carer, and volunteer communication. Combined key results areas include Stakeholder Communications (Internal and External including staff, patients, carers, and volunteers), Public Relations (Relationship Management), Crisis Management, Public Affairs (Media and Political) and Marketing Communications.

This annual report covers the work of the Communications Service from 1 April 2024 to 31 March 2025. Communication activity with patients, carers, and volunteers during 2024/25 is captured in the PCIS 12-month update reports. Additionally, stakeholder stories presenting feedback from patients, carers, and volunteers directly to the Board are a key feature of the Board's agenda.

Trust and confidence of our stakeholders can only be achieved through maintaining the highest levels of transparency. The work of the Communications Service and PCIS help drive our reputation locally, nationally, and globally through different channels by communicating with all stakeholders in a timely, accurate and consistent fashion. This in turn generates confidence, which ultimately supports the Board's vision and corporate objectives.

Within Communications, we believe that our values are the bedrock of our culture, guiding how we work with one another and our stakeholders.

## 2. LEGAL AND POLICY CONTEXT FOR COMMUNICATIONS

Communications is delivered in line with the State Hospital's Communications Strategy 2025/30, which supports the Hospital to achieve its vision and strategic objectives, respond to crisis situations, and meet its legal obligations:

### 2.1 Data Protection and Privacy Legislation

- *UK General Data Protection Regulation (UK GDPR) and Data Protection Act 2018*: Governs handling of personal data, ensuring secure, lawful, and transparent processing in all communications involving patient or staff information.
- *Privacy and Electronic Communications Regulations (PECR)*: Regulates electronic marketing (emails, texts), confidentiality of communications, and the use of cookies.

### 2.2 Freedom of Information Legislation

- *Freedom of Information (Scotland) Act 2002*: Requires public bodies to respond to information requests, unless exemptions apply, supporting transparency in communications.

### 2.3 Equality and Non-Discrimination Legislation

- *Equality Act 2010*: Prohibits discrimination and promotes accessibility, ensuring inclusive communication for all protected groups.
- *Fairer Scotland Duty (2018)*: Obligates public bodies to consider socioeconomic inequality when developing policies, services, and communications.

### 2.4 Healthcare-Specific Legislation plus Standards and Expectations

- *Carers (Scotland) Act 2016:* Mandates that carers are informed about their rights and available support.
- *Health & Care (Staffing) (Scotland) Act 2019:* Ensures safe staffing levels, indirectly supporting communications around workforce transparency.
- *Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016:* Covers statutory Duty of Candour and regulates treatment standards and nicotine products.
- *Mental Health (Care and Treatment) (Scotland) Act 2003 / 2015:* Framework for patient rights and treatment, with implications for sensitive and rights-respecting communication.
- *Patient Rights (Scotland) Act 2011:* Supports person-centred communication, ensuring patients are informed and involved in decisions.
- *Public Services Reform (Scotland) Act 2010:* Improves transparency, efficiency, and accountability across public services.
- *National Staff Governance Standard (4th edition, 2012)*: Promotes staff wellbeing, inclusion, and engagement in communications.
- *NHSScotland Workforce Vision (Everyone Matters), 2013*: Supports a motivated, person-centred workforce, emphasising effective staff communication.

### 2.5 Whistleblowing and Ethical Conduct Legislation

- *Duty of Candour Procedure (Scotland) Regulations 2018*: Requires openness and honesty following adverse events.
- *Public Interest Disclosure Act 1998 (PIDA)*: Protects whistleblowers who report wrongdoing, ensuring fair treatment and protection from retaliation.

2.6 Marketing and Advertising Standards

- *CAP Code (UK Code of Non-Broadcast Advertising and Direct & Promotional Marketing)*: Sets clear rules for fairness, transparency, and non-deceptive promotional materials.
- *Consumer Protection from Unfair Trading Regulations 2008*: Prohibits misleading or aggressive communications and marketing tactics.

2.7 Human Rights and Communications Ethics

- *Human Rights Act 1998*: Upholds individual rights, including respect for privacy and freedom of expression in public communications.

2.8 Health-Specific Communication Frameworks – Strategy / Guidance

- *NHSScotland Communication and Engagement Strategy 2020–2024:* Provides a framework for meaningful engagement with patients, staff, and stakeholders. May now be integrated into broader NHS Strategic Frameworks post-2024.
- *Healthcare Improvement Scotland – "What Matters To You?" (2016):* Encourages listening and patient-centred dialogue in care conversations.
- *Leading Quality Health and Care for Scotland (2023–2028):* Strategic vision to embed quality improvement and leadership in care delivery.
- *NHS Recovery Plan (2021–2026):* Sets direction for post-pandemic transformation, digital innovation, and service resilience—relevant to evolving communications.
- *Scotland's Digital Health and Care Strategy (2021 Update):* Supports digital-first approaches to patient and staff engagement.

2.9 State Hospital Annual Delivery Plans

Focus remains primarily on performance, high-level finance and workforce; drawing together key planning assumptions which reflect local priorities.

## 3. COLLABORATIVE WORKING

A key aspect of the Communications Service is the requirement for effective and regular collaborative working across all directorate structures and teams. Being independent from other functions, services, or directorates, ensures effective broader organisational confidence, dialogue and connection is maintained. This is something that has been achieved over many years.

Within the State Hospital environment, it is important for staff to be able to see a function that not only serves all staff and disciplines equally but is positioned correctly to do this through a joined up internal network of strong lines and links in all directions with communications in the centre.

Collaborative working with the Scottish Government Mental Health Team, Scottish Government Communications colleagues, Health Board Communications peers, the Mental Welfare Commission, and other partners is well established.

## 4. STAFFING / RESOURCES AND INVESTMENT FOR THE FUTURE

The Communications Service has an establishment of three posts:

- Head of Communications.
- Communications Specialist (previously PR & Digital Communications Officer).
- Communications Assistant (previously PR & Media Communications Officer).

It was agreed to replace the previous PR & Media Communications Officer (Band 5) vacancy with a part-time Communications Assistant (Band 4) post. The decision was influenced by financial considerations. While not without impact, it was necessary to ensure the Service remained within budget and was able to support longer-term resilience and succession planning. The Communications Assistant post was due to be advertised in January 2025, however due to the extensive work surrounding the Cabinet Office Accessibility Audit (all-consuming from December 2024 to March 2025), a decision was made to delay to around May or June 2025 when the Service was not under so much pressure.

In terms of development:

- The Communications Specialist is nearing completion of the 'New to Forensics' training to further enhance knowledge / personal development.
- The Head of Communications attended an Artificial Intelligence (AI) for use in Communications webinar and participated in an in-house Cyber event which tested our contingency plans in response to a cyber-attack.
- Both posts attended the Scottish Ambulance Service (SAS) 'Show and Tell' Sharepoint Online training in addition to attending national Intranet Insights presentations. They also participated in a Communications Organisational Development (OD) Strategy session.
- Familiarisation with video equipment and training was mainly paused in year due to workload pressures.

## 5. KEY PERFORMANCE INDICATORS (KPIs)

Established KPIs relate to the core Communications Service as detailed below:

| No | KPI | Source | Timescale | Status / Outcome |
|---|---|---|---|---|
| 01 | To produce a Communications Annual Report for presenting to the Board. | Board | Annually | **Continues to be met**<br><br>In year it was agreed to move presentation to the Board from October to April. |
| 02 | To produce the Board's Annual Report. | Board | By 31 October each year | **Continues to be met** |
| 03 | To produce at least 44 weekly bulletins for staff. | CEO | Annually | **Complete**<br><br>A bulletin was produced for every week of the year. |
| 04 | To produce special bulletins as a support to staff. | CEO | Annually | **Complete**<br><br>Thirty-nine were produced. |

| No | KPI | Source | Timescale | Status / Outcome |
|---|---|---|---|---|
| 05 | To produce Staff Newsletter 'Vision' twice a year as a minimum. | CEO | Annually | **Complete**<br><br>Nine editions were produced. |
| 06 | To deliver on 100% of all appropriate requests for Talks to the Community. | General Public | Annually | **Complete**<br><br>There were no requests during the year. |
| 07 | To respond promptly to all Media Enquiries. | Media | Annually | **Continues to be met** |
| 08 | Complete the 'Well Informed' section of the Staff Governance Self-Assessment Monitoring Tool. | Staff Governance Standard | Annually | **N/A**<br><br>There was no requirement for this during the year. |
| 09 | To attend at least four of the six State Hospital Board Meetings. | Board | Ongoing | **Continues to be met** |
| 10 | Ensure Board business is published on the Website including Board Schedule of Meetings, Public Notices, Agendas, Minutes, and Papers. | Board | Ongoing | **Continues to be met**<br><br>Additionally, after each Board Meeting a review of all Board papers takes place to identify information / communication for the staff bulletin, staff newsletter 'Vision,' Intranet, Website, Media, and Social Media as appropriate. |
| 11 | To attend 90% of NHSScotland Strategic Communications Network Meetings. | NHSScotland | Annually | **Continues to be met** via Teams. |
| 12 | To ensure representation at the annual NHSScotland Event. | NHSScotland | Annually in June | **Continues to be met as appropriate**<br><br>Comms did not attend the June 2024 virtual event. |

The table below details activity in 2024/25 not covered by KPIs:

| No | Workstream | Lead | Outcome | Key Result Area |
|---|---|---|---|---|
| 01 | Media Releases / Statements | Head of Comms | One Media Release and one Media Statement were produced. | Media Relations |
| 02 | Media Features | Head of Comms | One Media Feature was published. | Media Relations |
| 03 | Suspected Media Leaks | Head of Comms | Previously we only submitted a Datix for suspected media leaks. Following discussion with Risk Management, it was agreed early 2024/25 that a Datix be raised for all Media Enquiries and coverage. The process was reversed late 2024/25 as there was nothing to investigate if the enquiry or coverage didn't relate to a suspected media leak. | Media Relations |
| 04 | FOI Enquiries | FOI Lead | The number of FOI Enquiries is captured within the Information Governance Annual Report. | Public Relations |

| No | Workstream | Lead | Outcome | Key Result Area |
|---|---|---|---|---|
| 05 | Academic Published Articles | Research & Development Manager | The Research Committee Annual Report 2024/25 notes all published journal articles and the delivery of presentations. | Public Relations |
| 06 | Leadership Walkrounds | - | These were paused during the year. A "Once for Scotland" approach to Leadership Walkrounds is being explored and will commence in 2025/26. | Staff Relations |

## 6. QUALITY ASSURANCE (QA) OBJECTIVES

The table below details progress against QA objectives set for 2024/25:

### 6.1 Internal Communications

| No | QA Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 01 | Provide professional advice and direction to the Board, line managers and all teams. | Comms Strategy | Head of Comms | Ongoing | **Continues to be met**<br><br>This enables the influencing and shaping of communication planning and strategy at all levels, ensuring good communications practice is firmly embedded in everyday service development, delivery, and change. |
| 02 | Ensure effective communication with relevant stakeholders to share updates relating to strategic priorities including sickness absence and nursing resource utilisation. | Chief Executive / Service Strategy / Directors' Objectives | All Directors | Ongoing | **Continues to be met**<br><br>Specific focus was on sickness absence and Day Time Confinement. |
| 03 | Support the Board and Organisational Management Team (OMT) through dedicated staff bulletins covering each meeting. | Board / OMT | Comms | Ongoing | **Continues to be met** |
| 04 | Review and update of State Hospital publications / information sheets. | Comms Strategy | Comms | Ongoing | **Continues to be met**<br><br>Outstanding backlog was addressed during the year. Additionally, all information sheets were converted from .doc to .docx. |

| No | QA Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 05 | Review and update of State Hospital Banner Stands following rebrand. | Head of Comms | Comms | - | **On hold**<br><br>Awaiting rebranding in light of new Forensic Board for Scotland. |
| 06 | Produce bulletins, newsletters, posers, publications, and other communications to advise staff of what is happening in the Hospital and the wider NHS. | Comms Strategy | Comms | Ongoing | **Continues to be met** |
| 07 | Periodic review of Board Photo Boards and update as necessary. | Board | Comms | Ongoing | **Continues to be met** with older photos updated in year. |
| 08 | Review and update of Comms Audio Visual Photo Consent Forms. | Comms Strategy | Head of Comms / Information Governance | By Summer 2024 | **New for 2024/25**<br><br>**Complete**<br><br>Update involved new process for gaining consent. |
| 09 | Review of Board bulletin in respect of staff views. | Board Chair | Head of Comms | By end Dec 25 | **New for 2025/26**<br><br>**On track** |

## 6.2 External Communications

| No | QA Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 10 | Through effective communications, foster public and political confidence in the care and services provided to protect and enhance understanding of the Hospital. | Comms Strategy | Comms | Ongoing | **Continues to be met** |
| 11 | Report Communication incidents / leaks to the Media via Datix. | Comms Strategy | Comms | Ongoing | **Continues to be met**<br><br>Process changed and reverted back during the year. Current position is that a Datix will only be done where there is a suspected leak to the media. |

| No | QA Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 12 | Keep the Scottish Government up to date on all matters relating to media activity and any correspondence with patients and families and / or carers which may require government officials and / or Ministers to become involved. | Annual Review | Head of Comms | Ongoing | **Continues to be met** |
| 13 | Inform Non-Executives and other identified staff of major events which are likely to attract Media interest. | Board | Head of Comms | Ongoing | **Continues to be met** |
| 14 | Ensure information is provided in an accessible format as required. | Comms Strategy | Comms | Ongoing | **Continues to be met** |
| 15 | Undertake quarterly reviews of website content and maintain website action plan.<br><br>In addition, produce statistical report via Google Analytics. | Comms Strategy | Comms Specialist | Quarterly<br><br>Annually | **Continues to be met** |
| 16 | Undertake an annual review and update of the content on the ONELAN screens. | Comms Strategy | Comms Specialist | Annually | **Continues to be met**<br><br>Content is accurate and up to date. |
| 17 | Undertake annual reviews and updates of the State Hospital's Speakers' Directory and general presentation slides. | Comms Strategy | Head of Comms | Annually | **Continues to be met**<br><br>This update includes feedback from community talks. |
| 18 | Bi-annual review of Media Training requirements for Directors and other identified staff. | Comms Strategy | Chief Executive / Head of Comms | Autumn 2025 | **On track** |
| 19 | Familiarisation with 'Dealing with the Media' Guidance for State Hospital Spokespeople. | Comms Strategy | On-Call Directors / CEO | Ongoing | **Continues to be met**<br><br>Note - This should be read in conjunction with the State Hospital's approved 'Media Lines for On-Call Directors' which have been prepared to assist those responding to media enquiries. |

| No | QA Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 20 | Maximise key messages about the Hospital's work, role and the services provided thus raising awareness of the Hospital's image, profile, and potential with external audiences locally, nationally, and internationally. | Comms Strategy | Comms | Ongoing | **Continues to be met**<br><br>During the year, we drove this through our social media channels as a means of educating stakeholders. |
| 21 | Manage the Communications Service eControl Book. | Health & Safety | Head of Comms | Ongoing | **Continues to be met** |
| 22 | Review of 'all user' email permissions. | eHealth Sub Group | Head of Comms / Infrastructure Operations and IT Security Manager | Every two years | **Continues to be met**<br><br>Review undertaken in year. |
| 23 | Review and update of Comms responses to general enquiries. | Comms Strategy | Comms | By year end | **New for 2024/25**<br><br>**Complete**<br><br>Review and update undertaken in November 2024. |
| 24 | Review of all State Hospital videos on the State Hospital YouTube channel with a new to updating or removing. | Comms Strategy | Comms | By March 2026 | **New for 2025/26**<br><br>**On track**<br><br>The review will include ensuring the transcriptions are correct and meet website accessibility legislation. |

## 6.3 Strategy / Policy

| No | QA Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 25 | Conduct an interim review and update (if required) of the Communications Strategy, policies, and procedures. | Comms Strategy | Head of Comms | Annually | **Continues to be met**<br><br>Communications Strategy for 2025/30 developed and the Media Policy was reviewed and updated. |
| 26 | Regular review and update of the Pandemic Influenza Communications Strategy. | Infection Control Committee | Senior Nurse for Infection Control / Head of Comms | April 2025 | **Continues to be met**<br><br>Review undertaken. Pandemic Communications Strategy 2025/30 produced. |

| No | QA Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 27 | Undertake Equality Impact Assessments (EQIAs) for Communications. | Equality Act | Head of Comms | As required | **Continues to be met**<br><br>There are five EQIAs in place to support communications work. All were reviewed and updated during the year. |
| 28 | Undertake Data Protection Impact Assessments (DPIAs) for Communications. | GDPR | Head of Comms | December 2025 | **Complete**<br><br>All six existing DPIAs were reviewed and made obsolete. Content was streamlined info four new DPIAs covering all areas of Comms activity:<br><br>• The Use of Audio Visual.<br>• Staff Communications.<br>• Public Communications<br>• Media Policy. |
| 29 | Following handover of Intranet from eHealth to Comms, review and update Intranet Maintenance & Development Policy and associated Equality Impact Assessment (EQIA) to reflect changeover. | Comms Strategy / Equality Act | Head of Comms | Summer 2024 | **New for 2024/25**<br><br>**Complete**<br><br>Policy reviewed and replaced by guidance. The policy is now obsolete as is the associated EQIA. |
| 30 | Review of all State Hospital videos on the State Hospital YouTube channel with a new to updating or removing. | Comms Strategy | Comms | By March 2026 | **New for 2024/25**<br><br>**On track** |
| 31 | Review and update of Corporate Document Standards to include Records Management best practice. | Records Services | Head of Comms | By end 2026 | **New for 2025/26**<br><br>**On track**<br><br>The update is also likely to include document accessibility standards. |

## 7. QUALITY IMPROVEMENT (QI) OBJECTIVES

The following table shows performance against QI objectives set for 2024/25:

### 7.1 Internal Communications

| No | QI Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 01 | Redevelop the Intranet. The current Sharepoint site (now at end of life) will be replaced with the new 'Sharepoint Online' version which is being led nationally for all Boards by National Services Scotland (NSS). | National | Comms / eHealth | - | **Ongoing**<br><br>The project remains on hold nationally pending resources, governance approvals and other necessary requirements to ensure successful implementation across NHSScotland. |
| 02 | Maintain the State Hospital Photo Library. | Head of Comms | Comms Specialist | - | **Continues to be met** |
| 03 | Continue to undertake staff engagement exercises to support corporate objectives. | Comms Strategy | Project Lead / Designated Individual | Ongoing | **Continues to be met** |
| 04 | Support ad-hoc key events via dedicated staff bulletins / Vision / campaigns as appropriate. | Project Lead | Project Lead / Comms | Ongoing | **Continues to be met**<br><br>For example, visits and recruitment fairs. |
| 05 | Promote the work of Healthy Working Lives (HWL). | Values & Behaviours Group | OD Manager / PR & Media Comms Officer | Ongoing | **Continues to be met**<br><br>Achieved through the staff bulletin and the production of resources. |
| 06 | Raise staff awareness of the Hospital's sustainability work to meet net zero target. | Sustainability & Climate Change Group | Head of Estates / Comms Specialist | Ongoing | **Continues to be met**<br><br>Significant input went into promoting Climate Week 2024 from the development of a Communications Action Plan and promotional materials to an email footer, poster, social media posts, staff bulletin and Vision articles, dedicated Teams backgrounds, and the creation of a State Hospital Sustainability logo. |

| No | QI Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 07 | Support the 'Excellence Awards' and staff 'Long Service Awards.' | Values & Behaviours Group | OD / Comms | Annually | **Continues to be met**<br><br>Communications is a member of the groups responsible for organising and managing these events. |
| 08 | Support Speak Up week 2024. | National | HR / Comms | Annually around Sep / Oct | **Complete**<br><br>Significant resource was given to supporting this week from bulletin and Vision articles, an information sheet, the creation of pledge cards and posters to presentations, promotional items, social media posts, Teams backgrounds and a dedicated Communications Action Plan. |
| 09 | Annual redesign of the Weekly Staff Bulletin and Special Bulletin. | Board | Comms | Annually | **Continues to be met**<br><br>New design launched 1 April each year. |
| 10 | Review and further develop Communications Guides. | Head of Comms | Comms | - | **Continues to be met** |
| 11 | Review and further develop Standard Operating Procedures (SOPs). | Head of Comms | Comms | - | **Continues to be met** |
| 12 | Support HR initiatives. | HR | Comms | Ongoing | **Continues to be met**<br><br>Support was provided in respect of No Wrong Path, Recruitment (processes, pathways and job adverts), career fairs, new starts, Armed Forces Day, Cycle to Work, HR Directorate Development Day, Modern Apprentice, National Demonstrator Programme, New Student Placement, UK National Inclusion Week, South Lanarkshire Works, and HR themed awareness days. |

| No | QI Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 13 | Support Patient Initiatives. | Skye Centre Activity Centres | Comms | Ongoing | **Continues to be met**<br><br>In year, Comms supported the Beatson Cancer Charity Event / 5k run, Koestler Awards, Sports Week, Learning Awards, and Halloween / other activities. |
| 14 | Expand the existing range of Teams Backgrounds. | Comms Strategy | Head of Comms | Ongoing | **New for 2024/25**<br><br>**Complete**<br><br>Backgrounds developed included those specific to roles and functions as well as generic photo backgrounds.<br>Promotion of the use of backgrounds continues. |
| 15 | Support Occupational Therapy (OT) Week. | OT | Head of Comms | Each November | **New for 2024/25**<br><br>**Complete**<br><br>Campaign included stand at Reception, social media posts, and photos. |
| 16 | Support IT Security Initiatives. | eHealth | Head of Comms / Infrastructure Operations and IT Security Manager | Each November | **New for 2024/25**<br><br>**Complete**<br><br>Campaigns included phishing and cyber security. |
| 17 | Produce a suite of quality graphics to support Clinical Quality with its role and remit. | Clinical Quality | Head of Comms | Spring 2024 | **New for 2024/25**<br><br>**Complete** |
| 18 | Produce MS Forms to support the work of the Communications Service. | Comms Strategy | Head of Comms | Spring 2024 | **New for 2024/25**<br><br>**Complete** |
| 19 | Build capacity for workload ensuring full complement of staff is in place. | Board | Head of Comms | - | **New for 2024/25**<br><br>**Complete** |
| 20 | Review Communications categories on Datix relating to the media. | Head of Risk & Resilience | Comms | Sep 2025 | **New for 2024/25**<br><br>**Complete** |

| No | QI Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 21 | Communications to take over responsibility for investigating / closing off Datix submissions relating to the media. | Head of Risk & Resilience and Information Governance & Data Security Officer | Comms | Sep 2025 | **New for 2024/25**<br><br>**Complete**<br><br>However there is now no need for this as we are only submitting a Datix for suspected media leaks which are investigated by Information Governance. |
| 22 | Explore Artificial Intelligence (AI) for use in communications. | NHSScotland Strategic Comms Group / eHealth Projects | Head of Comms | Ongoing | **New for 2024/25**<br><br>Attended AI and Comms Webinar in June 2024 as a starting point. Currently piloting the use of AI for general communications. |
| 23 | Explore Microsoft Sway for staff communications. | Head of Comms | Comms Specialist | - | **New for 2025/26**<br><br>Explore when Sharepoint Online is implemented as our new Intranet. |
| 24 | Develop Asset Registers for Communications. | GDPR | Head of Comms | Dec 2025 | **New for 2025/26**<br><br>**On track** |

## 7.2 External Communications

| No | QI Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 25 | Issue Media Releases surrounding good news stories, ensuring the safety and security of patients, staff and visitors is not compromised. | Comms Strategy | Comms | - | **Continues to be met** |
| 26 | Continue to invite visitors to the Hospital to learn about our work. Visitors include MSPs, Health Board Chairs and senior officials as well as other stakeholders. | Board | CEO / Directors | Ongoing | **Continues to be met**<br><br>Visits are captured in the Chief Executive's Report to the Board and are covered in the staff newsletter 'Vision' as appropriate. |

| No | QI Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 27 | Maintain links with other agencies and forensic services through the Forensic Network. | Comms Strategy | CEO / Medical Director / Other Professions | Ongoing | **Continues to be met** |
| 28 | Improve communications with partners about the Hospital's work, aims and successes and look for opportunities to work collaboratively. | Comms Strategy | Head of Comms | Ongoing | **Continues to be met**<br><br>Good relationships maintained with Scottish Government, Mental Welfare Commission and NHS Boards. |
| 29 | Review Memorandum of Understanding (MoU) with another National Board as a means of strengthening resilience within both Boards. | National Boards Collaborative | Head of Comms / Chief Executive | February 2026 | **Continues to be met**<br><br>MoU with the NHS Golden Jubilee reviewed and updated in February 2024. Next review 2026. |
| 30 | Undertake Video Training and practice sessions to enhance familiarisation. | Comms Strategy | Comms | Ongoing | **Slow progress is being made**<br><br>Familiarisation training will continue until individuals are proficient. This was paused in year due to workload pressures although some practice took place in June and November 2024. |
| 31 | Explore 'Social Media for Businesses' and ensure two- factor authentication is enabled. | eHealth | Infrastructure Operations & IT Security Manager | - | **Partly complete**<br><br>Two-factor authentication for Facebook is still being explored by IT. |
| 32 | Explore opportunity for the State Hospital to put a case forward for a State Hospital variant of the NHSScotland logo that more clearly identifies the State Hospital as an NHSScotland organisation. | Corporate Management Team (CMT) | Head of Comms | - | **On hold**<br><br>Will be explored when new Forensic Board for Scotland is formed. |
| 33 | Produce key messages / facts including information on items that can be easily misunderstood or can cause concern, e.g. patient outings, patients with autism, misinformation etc. | Comms Strategy | Comms | By March 2025 | **New for 2024/25**<br><br>**Complete**<br><br>This was done collaboratively with the Intellectual Disability (ID) Service. |

| No | QI Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 34 | Share Stakeholder Stories via the Website. | CMT | Head of Comms | - | **New for 2024/25**<br><br>**Complete**<br><br>Specific page created September 2024. |
| 35 | Redesign of both the Volunteer and Recruitment Sections of the website. | PCIS and HR | Head of Comms | By July 2024 | **New for 2024/25**<br><br>**Complete**<br><br>This involved the creation and promotion of volunteer roles both on the website and social media. |
| 36 | Following an audit in November 2024, ensure compliance against The Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018. | Cabinet Office Audit | Head of Comms | Within 12 weeks | **New for 2024/25**<br><br>Passed the re-audit in March 2025 with some actions outstanding which will be met in 2025/26. |
| 37 | Support the recruitment of Volunteer Roles through the website and social media. | PCIS | Head of Comms | Ongoing | **New for 2024/25**<br><br>**Continues to be met** |
| 38 | Produce narrative that covers process from admission to discharge, referring to reason for admission to the State Hospital. | Comms Strategy | Comms Specialist + ID Service RMO | By March 2026 | **Carried over from 2024/25**<br><br>**On track** |
| 39 | Create narrative around detention / restriction orders and review process / rights to appeal. | Comms Strategy | Comms Specialist + ID Service RMO | By March 2026 | **Carried over from 2024/25**<br><br>**On track** |
| 40 | Explore Instagram. | Comms Strategy | Comms | By March 2026 | **Carried over from 2024/25**<br><br>**On track** |
| 41 | Redesign of Job Adverts on social media. | HR | Comms Specialist | By end Dec 2025 | **New for 2025/26**<br><br>**On track** |
| 42 | Produce a series of short educational videos that can be placed on the State Hospital website, YouTube, and other social media channels. | Comms Strategy | Comms | By March 2026 | **New for 2025/26**<br><br>**On track** |

| No | QI Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 43 | Create 'Meet the Board' Video. | Staff Governance Committee / HR | Comms | March 2026 | **New for 2025/26**<br><br>Comms has asked the Committee to clarify purpose and audience. |

## 7.3 Collaborative Working

| No | QI Objective | Source | Lead | Timescale | Status |
|---|---|---|---|---|---|
| 44 | Develop the leadership needs of NHSScotland Communications professionals: Directors of Comms and Comms Heads of Service. | Strategic Comms Group | Strategic Comms Leadership Sub Group | Ongoing | **Paused**<br><br>This work has been paused since the beginning of the Covid-19 pandemic. |
| 45 | Participate in State Hospital development sessions aimed at informing our Annual Delivery Plans and Medium-Term Plans. | Head of Corporate Planning, Performance and Quality / OD Manager | Head of Comms | 31 October 2024 | **New for 2024/25**<br><br>**Complete**<br><br>Three-year mission / objectives for the Communications Service were developed and shared at the event. As part of this, the Communications Service had to clarify its purpose and vision. |

## 8. EVALUATION OF EFFECTIVENESS

All core Communications objectives, corporate objectives, and legislative requirements were met in 2024/25. The following are examples of positive outcomes evidencing effectiveness achieved during the year.

### 8.1 Internal Communications

- Met corporate responsibility by attending strategic planning events to inform the development of the Annual Delivery Plan (ADP) and Medium-Term Plan (MDP). Also participated in Job Evaluation panels which helped ensure posts were looked at in a timely fashion.

- We facilitated a Community Engagement & Systems Redesign session with State Hospital engagement leads and the Strategic Engagement Lead from Healthcare Improvement Scotland (HIS).

- The 2024 iMatter Survey saw a response rate of 72%. The Board's Employee Engagement Index (EEI) was 75 (both scores were the same as last year, 2023).

- Requests for printed materials continued, evidencing fit for purpose and in demand. Our Publications Databases captures 75 information sheets, 18 banner stands, and 36 departmental initiatives. These were all reviewed and updated as appropriate in year.

- Developed graphics to support the Clinical Quality Strategy, Volunteer Handbook, Equality documents, Speak Up Week and Sustainability. These are timeless and can be used repeatedly to promote these key areas of our work.

- Workshops / events / training promoted via the Staff Bulletin were well attended evidencing that staff read the bulletin, and the bulletin remains an effective means of promoting these activities.

- With positive feedback, the staff bulletin and staff newsletter 'Vision' continued to keep staff and volunteers updated on all the latest news internally and externally. Staff requests for dedicated staff bulletins continued to be high, as were staff contributions to weekly staff bulletins and Vision.

- An initial exploration of SWAY was undertaken as a new method of communication. We will explore further when Sharepoint Online is implemented.

- Despite the need for redevelopment, the Intranet continued to play a vital role, creating a virtual environment where staff could stay informed, connect, communicate, and share. Our Intranet Upgrade Action Plan remained active, ensuring a seamless transition when approval is granted to migrate to SharePoint Online. The Communications Service page on the Intranet was reviewed and updated in year.

- The 'All User Email Request' icon on the Intranet was well utilised in year, accounting for over 90% of requests. The email system remained effective for issuing communications that were either urgent or not for inclusion in the staff bulletin, e.g. weather warnings, grounds access time changes, and items sought or no longer required, works on site, programme downtimes, public holiday staffing, lost property etc.

- Feedback arising from the policy consultation process (housed on the Intranet and advertised through the staff bulletin and email system) evidenced that staff took the time to read formal communications, respond and contribute to policy improvement.

- Communications staff are key members of numerous groups including the following:

    - Board
    - Corporate Management Team (CMT)
    - Gold Command (D&G Data Breach)
    - Organisational Management Team (OMT)
    - AfC Job Evaluation Steering Group
    - AfC Reduced Working Week (RWW)
    - Business Classification Scheme (BCS) Project Team,
    - Climate Change & Sustainability Group
    - Daytime Confinement (DTC) workstream
    - eHealth Sub Group
    - eRostering Project Team (now changed to Allocate Optima) / Loop
    - Freedom of Information (FOI) Committee
    - HCSA Project Team
    - Healthy Working Lives (HWL) Group
    - Staff Recognition Steering Group (Excellence Awards and Long Service Awards)
    - Task & Finish Group (Attendance Management)
    - Workforce Wellbeing & Organisational Development Delivery Group

- The continued development of Communications Guides and Standard Operating Procedures (SOPs) in year has strengthened governance and effectiveness in terms of service delivery.

### 8.2 External Communications

- Our biggest achievement of the year was ensuring compliance with The Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018. This remediation work involved adjustments to the coding behind the website, alterations to the way the information on the website was presented, and remediation of nearly 1000 documents; mainly PDF files which involved having to tag every cell in every table in every document. This work was carried out in-house by the Communications Service. It was resource-intensive and highly challenging. The key points for noting are:

    - The significant workload placed on the Communications Service from December to March 2025. All other work was paused during this time unless absolutely essential.
    - The ongoing retrospective remediation of PDFs in 2025/26, which remains a substantial task for the Communications Service. This is outlined in our Website Accessibility Statement - which can be found within the footer of each web page - together with timescales for completion.
    - The broader impact of this work on all departments at the State Hospital.

- Despite the challenges of accessibility, the website continues to effectively meet the needs of our stakeholders. Quarterly checks throughout the year ensured that content on the main pages aligned with the FOI section, with this cross-referencing maintained as good practice. The Website Maintenance & Development Action Plan remained instrumental in keeping content relevant and up to date. The use of Google Analytics helps us track and report website traffic and user behaviour.

- A two-page article “Research into practice: Implementation of positive behaviour support in a high secure care intellectual disability service” by Zenzo Dube, Senior Charge Nurse, the State Hospital was published in the International Association of Forensic Mental Health Services (IAFMH) newsletter (volume 9, issue 2 - 2024 Q2).

- Our Media Release “State Hospital and University Shortlisted for Prestigious Nursing Times Award” of 17 July 2024 was coved by the Scotsman, Edinburgh Evening News, the Daily Record, Renfreshire24, and our local Lanark & Carluke Advertiser.

- Through the effective management of media enquiries, we were able to protect the Hospital’s reputation by either (1) preventing what could have been a potential news story or (2) by lessening the impact of a negative story through rebutting inaccuracies and providing information to ensure fair and balanced coverage. All media enquiries were shared with the Board, Scottish Government colleagues, and the Mental Welfare Commission (MWC) in support of knowledge exchange, collaborative working, and consistent messaging. Eleven media enquiries were received in year ranging from enquiries about individual patients to patients with autism and learning disabilities, female provision, sirens, documentary, staff wellbeing costs, and staff suspensions.

- Media Lines for On-Call Directors were reviewed and enhanced over the course of the year.

- During the year, 31 patient stories were published in the media without any prior media enquiry - some appearing in multiple newspapers. These mainly related to patient Court appearances. Additionally, there were nine instances of 'withheld newspapers' - cases where an article about a patient was published but subsequently removed by us before the newspaper was distributed to patients.

- Social media platforms X, Facebook, and LinkedIn were utilised to enhance stakeholder awareness about the Hospital and its services, with a total of 322 posts published in year. We have developed a Social Media Planner to ensure effective presence throughout the year. These channels are key for recruitment – we post each vacancy three times on each channel (i.e. nine posts for each vacancy). We also have a presence on Messenger, YouTube, Wikipedia and Google My Business. In terms of the latter, we responded to all reviews of the State Hospital submitted via this platform. In year we also created a Social Media Action Log for fake or negative social media posts / comments.

- The general State Hospital mailbox (tsh.info@nhs.scot) continued to receive a steady flow of enquiries, demonstrating its effectiveness and popularity as a valuable resource. These were responded to promptly and effectively.

- State Hospital promotional items remained in high demand throughout the year, particularly for recruitment events and fairs, and infection control awareness. In year they were also produced to support national initiatives such as Speak Up Week and Climate Week as well as Non-Executive visibility.

- Hosting visits to the Hospital continued as a means of engaging a broader audience, showcasing our work, and facilitating the sharing of best practices and networking. Information about visits during the year were captured in the Chief Executive’s Report at each Board meeting. Key visits were also covered in the staff newsletter ‘Vision’.

- The Chair provides feedback from the NHSScotland Chairs’ Meeting at each Board meeting, keeping the Board informed of national developments, including updates on targets and priorities. Similarly, the Chief Executive shares insights from national CEO meetings.

## 9. SUMMARY / CONCLUSION

### Staffing

The Communications Service operated below its full staffing complement all year, which presented certain challenges in terms of service delivery. Despite this, the team of two remained dedicated and resourceful ensuring that key objectives were met, and that the quality of work was maintained. While the reduced staffing levels required careful prioritisation and a more agile approach to project management, the team demonstrated resilience and continued to deliver high standards of communication across all areas.

Going forward, appointing a part-time Band 4 Communications Assistant to fill the full-time Band 5 PR & Communications Officer vacancy, will provide some support to the team but it will not offer the same capacity for growth, resilience, and service expansion that a like-for-like replacement would deliver. This reduced capacity also limits our ability to effectively meet the organisation's increasing demands and the Board's expectations. The decision was influenced by financial considerations, and while not without impact, it was necessary to ensure we remain within budget and can support longer-term resilience and succession planning.

In year, all mandatory training was up to date, staff objectives were developed and reviewed, staff appraisals were undertaken, and Personal Development Plans (PDP) were in place.

### Performance – Target and Objectives

The Communications Service consistently excelled in delivering high-quality, comprehensive communications to stakeholders, ensuring that key objectives were met with efficiency and professionalism. In addition, others responsible for communication across the organisation continued to successfully achieve their goals, contributing to the overall effectiveness of collaborative efforts.

All core communications functions - encompassing key performance indicators, quality assurance, and quality improvement objectives - were fully delivered. The service not only met all legislative requirements but also achieved financial targets and identified savings, demonstrating strong fiscal responsibility.

These achievements were made while adhering to the core values and principles that the Board sponsors, and that are promoted throughout NHSScotland. The commitment to these values ensured that standards were met, fostering continued success and furthering the impact of our work.

### Service Delivery

The Communications Service maintained a highly proactive approach throughout the year, consistently delivering timely, high-quality work across all areas. This commitment to excellence ensured that each project was carefully managed and tracked through well-maintained action plans.

All communications strategies and policies were regularly reviewed and kept up to date, ensuring their ongoing effectiveness. Supporting documentation was meticulously maintained, with planned reviews scheduled for those documents nearing their end of life. A notable achievement was the development of the Communications Strategy for 2025/30, which builds on the successes of the 2020/25 strategy, further strengthening our communications framework for the future.

Focus remains on continuously developing the Communications Service to enable the most efficient and impactful use of resources. A key component of this development is building capacity for the future, with a particular emphasis on enhancing resilience, succession planning, and fostering sustainable growth.

Equally important is the need to stay current with and embrace digital technologies and advancements, ensuring that communication channels remain innovative and effective in meeting the needs of stakeholders.

Our strategic approach will ensure that the Communications Service is well-equipped to meet the demands of tomorrow while maintaining its high standards of excellence today.

## 10. LOOK BACK

Areas of focus in 2024/25 as identified in last year's annual report are shown below together with an update:

- Implement Sharepoint online (new Intranet) – This project is being led nationally; however we are in a state of readiness for when we get the green light to go ahead.
- Develop audio-visual materials – in particular, video – On track for timeline of March 2026.
- Develop a Communications Information Asset Register – This work was paused in light of Website Accessibility Audit and subsequent workload.
- Review DPIAs – Complete. A full review of the existing six DPIAs was undertaken. These were subsequently made obsolete and replaced by four new DPIAs:
- Complete the State Hospital Rebranding – On hold in light of new Forensic Board for Scotland.
- Recruit to ensure staffing establishment of three is maintained – The post will be advertised by Summer 2025.

## 11. LOOK FORWARD

Areas of focus in 2025/26 include:

- Implement Sharepoint online (new Intranet).
- Develop a Communications Information Asset Register.
- Develop audio-visual materials – in particular, video.
- Complete the State Hospital Rebranding – On hold in light of new Forensic Board for Scotland.
- Recruit, support and develop the Communications Assistant.
- Continue to develop the Communications Service to enable the most efficient and impactful use of resources.
- Embrace the evolving landscape of digital technology including AI.

Caroline McCarron Chart.PR MICPR
Head of Communications
14 April 2025

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 23 |
| Sponsoring Director: | Director of Finance and eHealth |
| Author(s): | Head of eHealth, Infrastructure Operations and IT Security Manager |
| Title of Report: | Network & Information Systems (NIS) Update |
| Purpose of Report: | For Noting |

## 1 SITUATION

The State Hospital (TSH) was subject to a compliance progress review of Network & Information Systems by Cyber Security Scotland in October 2024, following the previous review in October 2023.

## 2 BACKGROUND

In 2020 the Scottish Health Competent Authority commissioned a three-year programme of audits and reviews of health boards to evaluate compliance with the Network & Information Systems (NIS) regulations. The initial audit programme was completed and unless incident reports or significant system changes in a health board merit a more frequent audit exercise, audits are conducted every third year – with the next for the State Hospital due in 2026. In intervening years, including 2024, Compliance Reviews are being undertaken – to which this report relates - the primary objective of the review being to assess progress on implementing the recommendations from the previous full audit and note progress on the control requirements.

## 3 ASSESSMENT AND OUTCOMES

### 3.1 2024 OUTCOME

Evidence was submitted up front to the reviewers – each piece requested for the review being "mapped" and cross-referenced to one or more controls set out. The documentary evidence was then independently reviewed and assessed for compliance.

Our review submission was successful in achieving an extremely positive outcome.

The overall assessment was a rating of 78% - an improvement on the 76% from 2023 – and we are recognised as having strength across the organisation and a high level of performance, being a strongly-performing board with a clear commitment to the NIS audit programme.

- All 17 categories continue to be rated above the 60% compliance level, with 9 being 80% or better, and two at 100%.

- The number of controls that have been achieved is 66% – also above the 60% compliance level.
- None of the 68 sub-categories are below 30% compliance (2023 -1) – with 39 (2023 – 36) rated above 80%.

We have therefore now achieved the targeted full KPI compliance of 60/60/0.

The report once again recognised the engagement of the Board – noting that the concluding management meeting "was exceptionally well attended by both executive and non-executive members, including the Chair and Chief Executive."

### 3.2 NEXT STAGES

The NIS lead and team will continue to review the remaining areas for development, addressing these where possible for the next review in 2026.

2024's outcome being the second year of the three-year cycle towards that next full review, certain pieces of work are still being developed on an ongoing basis such as business continuity and disaster recovery desktop exercises (completed recently in March 2025), and further securing our digital infrastructure by removing/replacing legacy systems.

The aim is for our overall interim compliance score to increase above 80% and for all areas of the review to remain on a compliant rating.

The relevant actions continue to be tracked by the monitoring group

## 4 RECOMMENDATION

The Board is invited to note the content of the report.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy / ADP** | N/A |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **3. Better Value**<br>h) Deliver the actions identified by the NIS audit, to maintain cyber security and resilience. |
| **Workforce Implications** | N/A |
| **Financial Implications** | N/A |
| **Route to Board**<br>Which groups were involved in contributing to the paper and recommendations | eHealth subgroup<br>IGG<br>CMT |
| **Risk Assessment**<br>(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**<br>(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<br>☑ There are no privacy implications.<br>☐ There are privacy implications, but full DPIA not needed<br>☐ There are privacy implications, full DPIA included |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

| | |
|---|---|
| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 24 |
| Sponsoring Director: | Acting 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 & Wednesday)*: 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 17th April 2025 and the next Project Oversight Board is scheduled for 15th May 2025. At the meeting of 17th April the Programme Director provided an update on the current status on the project, the Project Risk Register and financial details

## 3. ASSESSMENT

### a) General Project Update:

The project is in the final stages. All quality targets are being met, the timescale has moved (see Project Timescales and Progress at point 3b below) and costs are projected to overspend (see Finance – Project Cost at point 3d below).

## b) Project Timescales & Progress

The most recent accepted programme revision is rev 65b, submitted in February 2025 with a forecast completion date of 18th April. Revision 67 has been submitted and is under review at the time of writing. This forecasts completion on 30th May.

The installation of technology is complete. Key remaining works prior to Practical Completion are:

- Remedy of issues identified during Site Acceptance Testing (SATs)
- A quantity of other works requiring to be addressed prior to Practical Completion.

## c) Site Acceptance Testing

SATs takes place in order to test:

- Each Security system and the significant elements and functions of that system
- The integration of the various systems through the “Cortech” Security Management System and the related Cause and Effect programming
- The resilience arrangements in place to ensure contingencies exist in the event of partial or total failure of any individual system
- Performance during periods of high activity such as multiple and varied alarms

Each test is awarded a score:

- Status “A” – Proceed - Test completed to satisfaction and accepted with no further comments.
- Status “B” – Proceed - Test completed to satisfaction and accepted with comments.
- Status “C” – Do not proceed with this element - Test not completed to satisfaction and not accepted. (The award of a Status “C” to any element of the SATs results in a failure of the overall test.)

SATs of the security systems installed by Securitas took place between 10th March and 10th April, approximately 17,000 individual tests were undertaken across 165 subject areas and 15 security systems, the results are as follows:

110 (67%) subject areas were awarded an “A” (pass)
28 (17%) subject areas were awarded a “B” (pass with comments)
27 (16%) subject areas were awarded a “C” (fail) with remedial actions and retesting required

This process has demonstrated the value of SATs in testing all elements of the system and finding areas that require attention before full acceptance of the system and the award of Practical Completion. The remedies to all of the issues identified as requiring attention are relatively straightforward and there are no issues that demonstrate a fundamental failure of requirement, design or performance.

Securitas will begin the process of addressing the areas that were awarded a “C” on April 14th. A draft programme submitted on 11th April estimates that six weeks will be required to remedy all issues and retest each. At the time of writing this programme has not been reviewed or accepted by The State Hospital team.

## d) 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 continue to be affected by changes in the project timescale. The project currently has a potential overspend (exclusive of VAT) of approximately £966k. This has increased by approximately £96k since the February 2025 report to the Board. The main components of this increase are Project Advisor costs and Staff costs, both now projected to mid-June 2025.

The key project outline at 12th April 2025 is:

| | |
|---|---|
| Project Start Date: | April 2020 |
| Planned Completion Date: | May 2025 (draft programme rev. 67) |
| 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 12/04/25: | £9,758,378 |
| Total costs to date (exc. VAT & retention) at 12/04/25: | £9,653,006 |
| Total costs to end of project (Exc. VAT & retention) | £ 105,372 |

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 Scottish Government (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 SG 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.

Discussions are open with SG Capital Team in relation to the predicted project team expenditure of circa £108k. This amount will conclude the project and enable the service to move to business as usual

A rounded breakdown of actual spend to date (Exc. VAT) at 12/04/25 is:

| | |
|---|---|
| Securitas | £ 7.299m |
| Thomson Gray | £ 1.241m |
| Doig & Smith | £ 0.008m |
| HVM | £ 0.192m |
| Staff Costs | £ 1.021m |
| Miscellaneous | £0.002m |
| Income | -£ 0.110m |
| **Total** | **£ 9.653m** |

VAT has been excluded from calculations of amounts paid due to the potential for final adjustments on project completion.

## 4 RECOMMENDATION

That the Board note the current status of the Project.

**MONITORING FORM**

| | |
|---|---|
| **How does the proposal support current Policy / Strategy / ADP /** | Update paper on previously approved project |
| **Corporate Objectives**<br>Please note which objective is linked to this paper | **3. Better Value**<br>i) Complete the security upgrade and move towards the development of the core security quality indicators. |
| **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 Board**<br>Which groups were involved in contributing to the paper and recommendations. | Project Oversight Board |
| **Risk Assessment**<br>(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**<br>(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;<br>✓ There are no privacy implications.<br>☐ There are privacy implications, but full DPIA not needed<br>☐ There are privacy implications, full DPIA included |

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

**AUDIT AND RISK COMMITTEE** **ARC(M) 25/01**

Minutes of the meeting of the Audit and Risk Committee held on Thursday 30 January 2025.

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

| | |
|---|---|
| **Chair:** | |
| Vice Board Chair | David McConnell |
| **Present:** | |
| Employee Director | Allan Connor |
| Non Executive Director | Stuart Currie |
| Non Executive Director | Pam Radage |
| **In Attendance:** | |
| External Auditor, KPMG | John Blewett |
| Acting Director of Security, Estates, and Resilience | Allan Hardy |
| Internal Auditor, RSMUK | Asam Hussain |
| Chief Executive | Gary Jenkins |
| External Auditor, KPMG | Stacey McKay |
| Director of Finance and eHealth | Robin McNaught |
| Head of Corporate Planning, Performance & Quality | Monica Merson [Item 10 onwards] |
| Director of Workforce | Stephen Wallace [Item 5a] |

## 1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting and also noted Ms Stacey McKay, KMPG was attending the meeting today. Apologies were noted from Margaret Smith, Head of Corporate Governance and Michael Wilkie, External Auditor, KPMG.

## 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 Committee approved the minutes of the previous meeting held on 26 September 2024.

The Committee:

1. Approved the minutes held on 26 September 2024.

## 4 MATTERS ARISING – ROLLING ACTION LIST UPDATE

There were no matters arising that were not on the agenda today. The Committee received the action list and noted the actions from the last meeting and agreed that all actions were now closed.

The Committee:

1. Noted the Action List and agreed that all items had been addressed and were now closed.

**INTERNAL AUDIT**

## 5 INTERNAL AUDIT REPORTS

a) Statutory and Mandatory Training

The Committee received the Internal Audit Report on Statutory and Mandatory Training and Mr Wallace joined the meeting at this point. Mr Hussain outlined the key aspects including the agreed scope of the audit, the outcomes and actions and highlighted that the opinion was 'Reasonable Assurance' with three medium actions noted as detailed within the report.

Mr McConnell thanked Mr Hussain for the report and the overview provided. Mr Wallace agreed with the outcome and action points noting that the training guidance would be beneficial and suggested that clarity around what compliance level percentage should be achieved would be helpful, in particular for staff moving jobs within the State Hospital (TSH). He added that the second action in the report would be explored to establish if managers would be able to access information relating to non-compliance within their staff compliment. Mr Wallace added that the Workforce Governance Group monitors this area in terms of oversight. Mr McConnell thanked Mr Wallace for his supporting comments and welcomed discussion from members and attendees regarding this.

Mr Currie advised that he found the report helpful and highlighted the challenges around the interpretation of mandatory with regard to this training and the reasons cited for non-compliance. He concurred with Mr Wallace in relation to what percentage of staff would be required for assurance given the turnover of staff at any given time and noted that the report was helpful in highlighting the clear line of escalation.

Mr Wallace highlighted that the percentages achieved by TSH compared favourably when benchmarked against other NHS Boards and had consistently achieved between 85-90% in recent years, whereas many other NHS Boards achieved below 80%. He concurred with Mr Currie's point about 'mandatory' interpretation and the reasons given for non-compliance and that staff on long term sick were not included in the figures. He noted a risk scale was used with other groups to ensure data was accurate and that a valid reason was noted for staff who had not completed training.

Mr Hussain acknowledged Mr Currie's helpful observations and the challenges experienced by managers in maintaining safe staffing levels whilst ensuring training compliance. He noted the intention to increase visibility in relation to monitoring the workforce, exploring ways to address obstacles preventing wards from achieving training compliance which it was hoped would encourage staff to complete the training more quickly and improve performance. Mr Hussain agreed with Mr Wallace's point relating to TSH performance compared with other NHS Boards and the difficulties in obtaining 100% compliance.

Ms Radage noted that the paper provided helpful context around what was happening across other NHS Boards and how important it was to promote a culture and understanding that training compliance was an essential part of the management role.

Mr Wallace agreed with the frustrations experienced around training and noted that TSH had significantly more training modules than other NHS Boards: NHS Greater Glasgow and Clyde currently had nine statutory and mandatory training modules. He explained that Protected Learning Time (PLT) nationally was incorporated within the modules however, this was likely to change and become a 'Once for Scotland' approach. He commented that Workforce Governance Group would look at each department's performance and that the dashboard would show all KPI's together and highlight non performing areas.

Mr Jenkins noted that on occasion it had been necessary to deprioritise training due to staffing challenges. He referred to the recent decisions by the Board in relation to nursing resourcing which should mitigate the risk of reverting to deprioritising training in future, stabilise the staffing position and facilitate the ability to release staff for training going forward; additionally PLT would assist in

achieving this goal. He added that there are discussions in progress to understand what modules staff should be undertaking and that the ongoing development of digital dashboards enabled managers and others to have real time information available to them to act. Mr Jenkins confirmed that the situation was being addressed and improvements would continue to be sought throughout the management structure.

Mr McConnell referred to the management actions detailed in the report and asked if the timeframes were realistic. Mr Wallace confirmed that the timeframes were reasonable.

Mr McConnell thanked everyone for their contributions to the discussion.

Mr Wallace left the meeting at this point.

The Committee:

a) Noted the Internal Audit Report on Statutory and Mandatory Training.

## 6 INTERNAL AUDIT

### a) AUDIT PROGRESS REPORT

The Committee received the Audit Progress Report presented by Mr Hussain who highlighted that the Statutory and Mandatory Training report was being presented at today's meeting, however the Physical Health - Supporting Healthy Choices Audit report was currently in draft, with discussions having taken place with the Medical Director and feedback being awaited. Mr Hussain added that a request had been received since the last meeting to undertake a review around Rostering Compliance which would replace the Security Review and it was proposed that the Security Review would be rescheduled to take place in 2026. Mr Hussain asked the committee to formally ratify the request. He further asked members to consider the proposed list of reviews planned for 2025/26, based on the audit strategy and encouraged suggestion for any other areas the Committee felt beneficial.

Mr McConnell invited members to discuss the proposal of an additional review. Ms Radage questioned if the additional review would affect the Physical Health Audit alignment with the Audit and Risk Committee meetings. Mr Hussain confirmed that the Physical Health Audit report would be submitted for review at the Audit and Risk Committee in March and if the report was available sooner, it would be circulated to members.

Ms Radage suggested that it may be beneficial to consider an audit on recruitment given the new approaches being taken in this regard. Mr Jenkins concurred and informed members that a corporate KPI had been set following an improvement event and the length of time to for staff on boarding, including induction, had been highlighted as challenges in this respect. Mr Jenkins agreed to discuss this further with Mr Hussain and Mr Wallace.

**Action: G Jenkins**

Mr Hardy informed members that work was in progress in relation to the audit of security standards for high security which was being progressed in the context of a possible change in governance across forensic mental health. Mr Hardy noted the intention to action the audit in March and to share the findings with the committee. Mr McConnell thanked Mr Hardy for the added assurance.

**Action: A Hardy**

Mr McConnell sought the Committee's agreement to add the Roster Compliance Exercise to the audit plan and members confirmed their agreement.

Mr McConnell invited members to comment on the future review plans for 2025/26. Mr Jenkins suggested that, given the development of female high secure services at TSH this area would

benefit from some audit assurance in terms of how these services would be implemented. Mr Hussain highlighted that he was content with the operation of Financial Management Control and this review could be supplanted by new ideas and suggestions generated by the Committee.

### b) ACTION TRACKING REPORT

The Committee received the Action Tracking Report presented by Mr Hussain who provided an overview of the status of each action. Mr Currie noted the importance of being realistic about deadlines and ensuring adequate pacing of dates was considered to enable deadlines to be met without extensions. Mr McConnell thanked Mr Hussain for the reports and overview provided.

The Committee:

1. Noted the Audit Progress Report.
2. Noted the Audit Tracking Report.
3. Agreed that the Security Standards Audit would be formally reported to the Committee.
4. Agreed to add Roster Compliance and Staff on boarding/induction to the Audit Plan.

## INTERNAL CONTROL and CORPORATE GOVERNANCE

### 7 CORPORATE RISK REGISTER

The Committee received the Corporate Risk Register update presented by Mr Hardy who provided an overview of the report and highlighted there were 29 risks, in date, on the register, three high, 22 medium and four low risks. It was noted that 15 risks are at target level and 14 risks are out with. Mr Hardy added that positive work was ongoing in relation to the three high risks.

- Failure to prevent/mitigate obesity: There is a large piece of work taking place to address obesity levels within TSH from a risk and health perspective. It was acknowledged that the target levels have not been reached and so a full approach refresh is expected.
- Failure to utilise our resources to optimise excellent patient care and experience: Work in this area is almost complete: a dashboard is in the process of being finalised.
- Failure to complete Category 1 and 2 Reviews on Time: It was noted that timescales have returned to a safe level and, pending the conclusion on associated reviews, this risk is expected to move down the scale.

He further noted that one risk had moved up the scale in relation to the compliance levels for PMVA Level 2 training; these levels had improved and the target of 90% compliance was on track to be reached by the end of January.

Mr Currie asked if it would be beneficial to consider removing some low risks to enable a greater focus on the medium and high category of risk. Mr Hardy agreed and added that there was the intention to move some of these risks back to local management and subsequently consider removal from this report.

Mr Hussain suggested that it may be useful to illustrate the movement achieved since the last report in order to view the risk journey and progress made over a time period. Mr Hardy concurred and added that some risks had experienced obstacles to progress and consideration was being given around how to overcome these.

Mr McConnell agreed that information pertaining to the risk journey and trends over time would be useful to include and considered whether this information should be provided monthly, 6-monthly or as an annual summary. Mr Jenkins suggested that it would be advisable to view this data 6-monthly to yearly to provide a meaningful dataset. He added that yearly would likely be more beneficial to obtain a clearer picture of the risk movement and trends. He also suggested that an offline discussion take place in relation to presenting this data in a dynamic and longitudinal way to give the committee greater assurance of trends over time. Mr McConnell concurred and recommended that Mr Jenkins and Mr Hardy take this action forward around the financial year end

reports. Mr Hussain shared a report in the chat of the meeting to illustrate how the data showing risk progression over time could be illustrated.

**Action: G Jenkins / A Hardy**

Ms Radage asked why an update for FD90 was not included in the report. Mr Hardy noted that FD90 was currently static but that an update should have been included and would be included in the report for the next meeting.

McConnell thanked Mr Hardy for the report and members for their contribution to the discussion.

The Committee:

1. Approved the Corporate Risk Register.
2. Agreed that the data set should be reviewed to include the risk journey and included trends.

## 8 FINANCIAL POSITION UPDATE

The Committee received the Financial Position update presented by Mr McNaught who provided an overview of the report noting the continuation of a small adverse variance with a year-end break-even position forecast. He added that meetings continued to be held monthly with each directorate monitoring progress against achieving savings targets and maintaining a break-even position and both were projected to be met. He also noted that at a recent meeting, the Scottish Government had indicated they were happy with the current financial position and forecast for the year and a further meeting would take place in two weeks time to discuss cost pressures within the final quarter of the year.

Mr McNaught added that directorate meetings were underway to finalise the 2025/26 budget with individual saving plans identified within each. Directors and staff across management levels within each team were encouraged to be involved in budget discussions. Ms Radage agreed that it was a positive initiative to engage more junior staff in budget discussions and this would result in further support for the process.

Members were updated that the capital demands prioritised for 2024/25 had been achieved and would be fully utilised. Funding obtained from the Scottish Government in December would go towards upgrading the main x-ray machines and also audio visual equipment in the four case conference rooms, with work required to be completed by the end of March 2025.

Mr McNaught noted that TSH was on target across the three main capital revenue and savings targets for the current year. He acknowledged that another challenging year was expected in terms of setting similar levels of savings targets for the next year and discussions were underway with budget holders.

Mr Currie asked if there had been any discussion around the provision of multi-year allocations and noted that the comprehensive spending review taking place in NHS England may provide the Scottish Government with the ability to project multi year figures to allow for more comprehensive planning. He suggested that it may be helpful to have reserve list of projects by which to use surplus capital if applicable. Mr Currie also noted that it would be helpful to see the percentage of ‘one off’ savings as opposed to the recurrent savings during the year 2024/25.

Mr McNaught responded that increasing the recurrent savings percentage remains a priority. Within the capital group there was focus on the priority spends that are required each year and a rolling forecast covered the next two to three years which highlighted the capital demands which may occur during this period. He added that there was an ability to view this forecast to bring items forward with a view to being actioned in the last couple of months of the financial year. There was flexibility to accommodate smaller items as larger items have a lengthier procurement process which impacted on the ability to complete within tight deadlines. Finally, Mr McNaught noted that the whole system estates maintenance plan, reported to Scottish Government was very forward

looking in its approach in terms of the rolling maintenance requirements of the site. This would be reviewed by Scottish Government alongside reports from all other NHS Boards and an outcome awaited to establish if there would be longer term financial assurances generated for this type of work. There was no indication that revenue funding would be able to be viewed in advance of one year at present.

Ms Radage asked, with regard to the financial pressures noted under section 3.4 of the report, the likelihood of receiving a decision on whether these pressures would be factored into the year-end position going forward. Mr McNaught responded that the Scottish Government were sighted on both the nature and extent of these pressures and they would continue to be monitored against the current spend and trajectory. Mr McNaught assured members that this position was continuously monitored, especially towards the end of the final quarter.

Ms Radage highlighted that some areas were showing less than 50% of savings achieved after nine months, and asked how the savings targets required could be achieved during the final three month period. Mr McNaught responded that this was due to how savings were phased through the year and that he was confident that TSH was on track for the year end position.

Ms Radage further commented that it appeared that there was more focus on business support and partnering across the business as a whole to collaboratively achieve savings targets and innovate ways of being financially prudent. Mr Jenkins added that it may be helpful to bring a perspective to the Committee twice yearly detailing how TSH compared with other NHS Boards in Scotland in terms of their performance against financial targets. Ms Radage added that this information would be useful to provide some external context.

**Action: G Jenkins**

Mr McConnell thanked Mr McNaught for the report and members for their contribution to discussions.

The Committee:

1. Noted the Financial Position Update.
2. Agreed that bi-annual comparisons of performance against financial targets with other NHS Boards should be presented to the Committee.

## 9 AUDIT SCOTLAND NATIONAL REPORTS

The Committee received the Audit Scotland National Report update presented by Mr McNaught who noted that although there are no specific references regarding TSH, The Audit Scotland Report – 'NHS in Scotland 2024: Finance and Performance' contained relevant recommendations for all Boards regarding balanced financial position and identification of savings. He also highlighted the inclusion of a link to an additional Audit Scotland Report 'Fiscal Sustainability and Reform in Scotland' which, although not specific to NHS Scotland and health Boards, provided a general overview of pressures faced in the current financial environment in terms of sustainability and transparency.

Mr Currie commented that the report historically had not provided a great deal of guidance and the information included did not differ vastly from previous reports. Mr McNaught responded that there appeared to be a frustration around points previously raised not being taken forward from a Scottish Government and NHS Board perspective and Audit Scotland understood that the report could offer repeated information. Mr McNaught acknowledged that there was an understanding of the level of work required to be completed by the Scottish Government to facilitate the work to be done by NHS Boards.

Mr Jenkins agreed that there were some high level steps to be taken around the health infrastructure of the country, led at a national level. He noted that the report was indicative of the challenges in doing so both within the NHS and across the public sector more generally. Mr

McConnell agreed with the points made by Mr Jenkins and noted that report was a useful and well expressed resource.

The Committee:

1. Noted the Audit Scotland National Report.

## 10 FRAUD UPDATE / FRAUD ACTION PLAN

The committee received the Fraud Update and Action Plan presented by Mr McNaught who provided an overview of the report and highlighted that Counter Fraud Services (CFS) virtual sessions continued to be circulated and noted one matter which required review, related to an allegation around staff attendance, was unfounded and subsequently closed. He confirmed the Fraud Action Plan had been approved with CFS who had communicated positive feedback in relation to current actions.

Mr Connor enquired how TSH could be assured that CFS allegations had been explored appropriately. Mr McNaught advised that the CFS keep a record of all allegations investigated which verify and explain the outcome and the files are retained should a review be required.

Mr Jenkins suggested that a discussion prior to committee meetings would be helpful to share details of allegations with the Chair, and to provide additional assurance that the investigations had been comprehensive and should be added to the rolling action list. Mr McConnell agreed with the proposal and indicated that there would be further discussion on how this could be taken forward.

**Action: R McNaught**

The Committee:

1. Noted the Fraud Update.
2. Noted the Fraud Action Plan.
3. Agreed that the Committee Chair would receive additional briefing on investigations.

## 11 CYBER CRIME UPDATE

The committee received Cyber Crime Update presented by Mr McNaught which provided an update on the overall ongoing cyber risks and how these were being addressed. He highlighted the key aspects of the reported and noted that the police had not reported any major national or local specific risks within the last quarter. He also noted that there continued to be a strong awareness of the current risks reflected in the statistics which successfully quarantined any threats detected and the importance to remain vigilant as well as monitoring compliance levels of cyber security training for staff.

The Committee:

1. Noted the Cyber Crime Update.

## EXTERNAL AUDIT

## 12 AUDIT PLANNING PROGRESS REPORT 2024/25

The Committee received the External Audit Planning Progress Report 2024/24 presented by Mr Blewett who provided an overview. It was noted that the Audit Team were onsite undertaking the planning, risk assessment, process walkthroughs and looking at the monthly finance position. A full audit plan including, wider scope reporting, would be submitted to the committee in March.

Mr McConnell noted that there had been discussion within other NHS Boards in terms of audit fees. Mr McNaught noted that the Audit Scotland letter included an indicative percentage was only sent recently. Mr Blewett added that the new audit fee would be detailed within the full audit plan.

The Committee:

1. Noted the Audit Planning Progress Report 2024/25

## INTERNAL UPDATES FOR INFORMATION

### 13 FINANCE, eHEALTH and AUDIT GROUP UPDATE

The committee received the Finance, eHealth and Audit Group Update presented by Mr McNaught who confirmed that there are no matters requiring escalation to committee.

The Committee:

1. Noted the Finance, eHealth and Audit Group Update.

### 14 SECURITY, RESLILIENCE, HEALTH and SAFETY OVERSIGHT GROUP

The committee received the Security Resilience, Health and Safety Oversight Group presented by Mr Hardy who confirmed that there were no matters requiring escalation to the committee.

The Committee:

1. Noted the Security, Resilience, Health and Safety Oversight Group Update.

### 15 RELEVANT ISSUES TO BE SHARED WITH OTHER GOVERNANCE COMMITTEES

Mr McConnell proposed that the following issues be shared:

- The internal audit report on Statutory and Mandatory Training should be shared with the Staff Governance Committee, who should also be asked to note that e-rostering had been added to the internal audit plan. Clinical Governance Committee to be made aware that the Physical Health – Supporting Healthy Choices internal audit was not yet complete and would follow as soon as possible, being reported into the March Audit and Risk Committee.

**Actions(s) – Secretariat**

### 16 ANY OTHER BUSINESS

There was no other business raised by members.

### 17 DATE AND TIME OF NEXT MEETING

The next meeting will take place on **Thursday 27 March 2025 at 1pm** via MS Teams.

The meeting ended at 11:15am.

**THE STATE HOSPITALS BOARD FOR SCOTLAND**

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| Date of Meeting: | 24 April 2025 |
| Agenda Reference: | Item No: 25b |
| Report Author: | Head of Corporate Governance |
| 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 27 March 2025.

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|---|---|---|
| 1 | Internal Audit | The Committee received progress reporting on audit activity, and two finalised audits. The first related to patient physical health focused particularly on the aspects relating to Supporting Healthy Choices and had an outcome of reasonable assurance with some medium actions to be taken forward. The second related to rostering compliance within nursing and had a negative outcome of partial assurance. The audit had been requested to review this area as it had been anticipated that compliance was not at the required level. The Committee discussed the key elements of the audit in detail and the actions and lessons to be taken. There was agreement that this should be included in the internal audit cycle in the future to seek further assurance on this. The negative outcome of the audit will also be included in the Governance Statement for 2024/25.<br><br>The Committee also reviewed and agreed the draft internal audit plan for the 2025/26 year. |
| 2 | External Audit | The External Auditors advised progress on work relating to the audit for the current financial year, which was progressing well, and no concerns were escalated to the Committee. |
| 3 | Corporate Risk Register | The Committee received a report on the position on the Corporate Risk Register focused on high risks and noted that the revised presentation was helpful to demonstrate movement within risks. |
| 4 | Serious Adverse Events Reviews – Actions | The Committee noted the update in this respect and took assurance that there was progress in concluding actions arising from SAERS. The Committee noted the investigations outstanding, and the timescales involved which requires improvement. |
| 5 | Climate and Sustainability Report | The Committee received a six-month update on progress in this area, and there were no concerns raised. The Committee will |

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| | | consider the timing of reporting in the context of the need for annual reporting and linking to the Non-Executive Champion in this area. |
| 6 | Finance Update and Scottish Public Finance Manual Updates | The Committee received an update on the financial position noting that there was continued expectation of a breakeven position for 2024/25. The Committee also noted the updates to the Scottish Public Finance manual for awareness, taking assurance that the State Hospital (TSH) would ensure compliance as appropriate. |
| 7 | Update Reports: Counter Fraud Cyber Crime Policies | The Committee received and noted the quarterly summary of alerts received from Counter Fraud Services (CFS) as well as the summary of activity at local and national level relating to cybercrime risks. Further, the progress made to streamline policies within THS, and routine review and approval of existing policies within this framework. |
| 8 | Anchors Strategy | The Committee received reporting positively, agreeing that there had been great advances made in this regard, especially given the unique nature of the State Hospital, and its location. The comparison of metrics from the baseline to the 2023/24 year was noted, and that this would be submitted to Scottish Government. |
| 9 | Draft Governance Statement | The Committee reviewed the initial draft of the Governance Statement for the current year, noting the further updates to be added at conclusion of the year, prior to submission to the Board. |
| 10 | Review Standing Documentation and Accounting Policies | The Committee received reviews of the Board Scheme of Delegation and Standing Financial Instructions, and Accounting Policies noting that there were no proposed amendments to same. It was noted that work would progress to name the Officer responsible within the Scheme of Delegation, rather than that this being aligned to the governance committee. |
| 11 | Review of Board Standing Orders, Members Code of Conduct, and Committee Terms of Reference | The Committee noted that there were no proposed changes to the Standing Orders, or the Committee Terms of Reference. Revision to the Members Code of Conduct was greed taking the model code of conduct directly from the Standards Commission, as well as removing the section relating performance matters to delineate this aspect from the code of conduct. This was agreed and that a recommendation would be presented to the Board on this basis. |
| 12 | Internal Updates | The Committee received updates from the Finance eHealth and Audit Group, and the Security, Resilience, Health and Safety 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**

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| **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. |
| **Corporate Objectives** | **3. Better Value**<br>j) Strengthen corporate governance to ensure transparency and clear direction, both within and external to the organisation in line with the Blueprint for Good Governance. |
| **Workforce Implications** | None through reporting – information update |
| **Financial Implications** | None through reporting – information update |
| **Route to Board**<br>Which groups were involved in contributing to the paper and recommendations. | Board requested, pending approval of formal minutes |
| **Risk Assessment**<br>(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**<br>(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<br>✓ There are no privacy implications.<br>☐ There are privacy implications, but full DPIA not needed.<br>☐ There are privacy implications, full DPIA included |