HHSCP Committee
2 December 2020

HHSC Committee Report at 31 October (Month 7)

Report by: Elaine Ward

The Committee is asked to:
Consider the financial position of the HHSCP to Month 7 noting the underspend of £0.542m against a year to date budget of £216.036m.

1. NHS Highland financial position at Month 7 (October 2020)

1.1 At the end of Month 7 (October 2020) the overall financial position of NHS Highland is a deficit of £8.800m. This is in line with the agreed brokerage requirement included in the Annual Operating Plan. The positions assumes full funding of all Covid-19 mobilisation and remobilisation costs incurred to the 31 March 2021. The current estimate of requirements is £34.584m.

1.2 As yet unfunded elements of Covid-19 includes underachievement of savings, estimated at £12.000m, Adult Social Care transformation savings of £8.300m, and a proportion of the estimated spend on remobilisation plans.

Table 1 – NHS Highland Summary Income and Expenditure Report as at October 2020

Plan £m	Summary Funding & Expenditure	to Date £m	to Date £m	to Date £m	Outturn £m	Variance £m
1,006.074	**Total Funding**	417.722	417.722	-	1,006.074	-
	Expenditure					
386.673	HHSCP	221.816	221.605	0.211	384.782	1.890
215.894	Acute Services	125.013	125.045	(0.032)	218.058	(2.164)
157.621	Support Services	73.384	80.702	(7.318)	190.024	(32.403)
760.188	**Sub Total**	**420.213**	**427.353**	**(7.140)**	**792.865**	**(32.676)**
220.101	Argyll & Bute	127.035	126.024	1.011	222.009	(1.908)
980.290	**Total Expenditure**	**547.248**	**553.377**	**(6.128)**	**1,014.874**	**(34.584)**
(8.800)	Planned Deficit	(5.133)	-	(5.133)	-	(8.800)
34.584	Estimated Additional Covid Funding	-	-	-	-	34.584
-	**Surplus/(Deficit) Mth 7**	**(124.394)**	**(135.655)**	**11.262**	**(8.800)**	**8.800**

2. Highland Health & Social Care Partnership financial position at Month 7 (October 2020)

2.1 The October 2020 position reports a £0.542m underspend against a year to date budget of £216.036m.

2.2 The year to date position includes £4.171m of costs associated with Covid-19. The HSCP is expected to incur costs of £9.005m in relation to the response to Covid-19 by the end of the financial year. At this stage it is assumed that these costs, and the savings slippage of £1.703m will be fully funded by Scottish Government.

2.3 A breakdown across services is detailed in Table 2 with a breakdown across Health & Adult Social Care shown at Table 3.

Table 2 - HHSCP Financial Position at Month 7

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	Forecast Outturn £m	Forecast Variance £m
	HHSCP					
209.945	NH Communities	117.364	117.675	(0.311)	208.294	1.651
39.984	Mental Health Services	22.699	22.638	0.062	39.922	0.062
6.538	ASC Other	3.628	2.796	0.832	5.583	0.955
130.205	Primary Care	78.124	78.496	(0.372)	130.983	(0.778)
386.672	**Total HHSCP**	**221.816**	**221.605**	**0.211**	**384.782**	**1.890**
	Costs held in Support Services					
6.606	Covid Costs	4.150	4.171	(0.021)	9.005	(2.399)
4.102	Estimated Covid Remobilisation Funding	-	-	-	-	4.102
(3.100)	PMO Workstreams (excl housekeeping)	(1.808)	(1.048)	(0.761)	(1.397)	(1.703)
(14.215)	ASC Income	(8.121)	(9.234)	1.113	(15.365)	1.150
380.066	**Total HHSCP and ASC Income/Covid**	**216.036**	**215.494**	**0.542**	**377.026**	**3.040**

Table 3 - HHSCP Financial Position at Month 7 –split across Health & Adult Social Care

Current Plan £m	Detail	Plan to Date £m	Actual to Date £m	Variance to Date £m	F'cast Outturn £m	F/cast Variance £m
	HHSCP					
230.935	**Health**	**134.385**	**133.885**	**0.499**	**230.121**	**0.814**
149.131	**Social Care**	**81.651**	**81.609**	**0.042**	**146.905**	**2.226**
380.066	**Total HHSCP**	**216.036**	**215.494**	**0.542**	**377.026**	**3.040**

2.4 There is currently an overspend of £0.311m within North Highland Communities but an underspend of £1.651m is forecast by year end due to ongoing staffing vacancies and over recovery of income.

2.5 Whilst the position within Mental Health Services is closely in line with budget there is an overspend of £0.475m within Drug & Alcohol Service and Adult Mental Health due to spend on agency locums. There is a compensatory underspend of £0.536m in Learning Disability and Community Mental Health Teams due to ongoing vacancies.

2.6 Within primary care ongoing locum costs within 2C practices and the increased costs associated with prescribing Sertraline continue to drive the overspend position with GMS and GPS. An underspend within Dental Services is currently being reviewed with an expectation that an element of this will contribute to savings. The prescribing pressure is forecast to increase significantly between month 7 and the financial year end.

2.7 It is anticipated that across the HHSCP all housekeeping savings for 2020/21 will be achieved.

2.8 An underspend of £3.040m is forecast at 31 March 2021 this is based on the assumption that funding for Covid-19 related costs and savings slippage will be provided by Scottish Government.

3 Summary

3.1 The Finance report presented to the HHSCC on the Month 5 position referred to uncertainties around funding for Covid-19 costs and indicated that a funding allocation was anticipated to be made in October.

3.2 A funding allocation of £34.173m as made at the end of September. This reflected actual costs incurred in quarter 1 and an estimate of costs for quarters 2 through to 4. £4.635m of this funding was allocated to the HSCP.

3.3 An assumption has been made that all costs associated with Covid-19 and savings slippage will be funded by Scottish Government. This position is being monitored as Scottish Government continue to scrutinise returns submitted by all NHS Boards.

3.4 There remains a gap between the costs of delivering ASC services and the funding received from Highland Council. Discussions between both parties and Scottish Government continue. The reported position is based on a different set of circumstances from normal service provision and does not reflect business as usual delivery. This is being reviewed via the joint NHS Highland and Highland council project to review service provision and the associated cost base.

4 Recommendations

The Committee is asked to consider the financial position of the HHSCP to Month 7 noting the underspend of £0.542m against a year to date budget of £216.036m and a forecast full year underspend of £3.040m against a budget of £380.066m.

Elaine Ward
Deputy Director of Finance
20 November 2020

HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE

2 December 2020

COVID Update and Social Mitigation

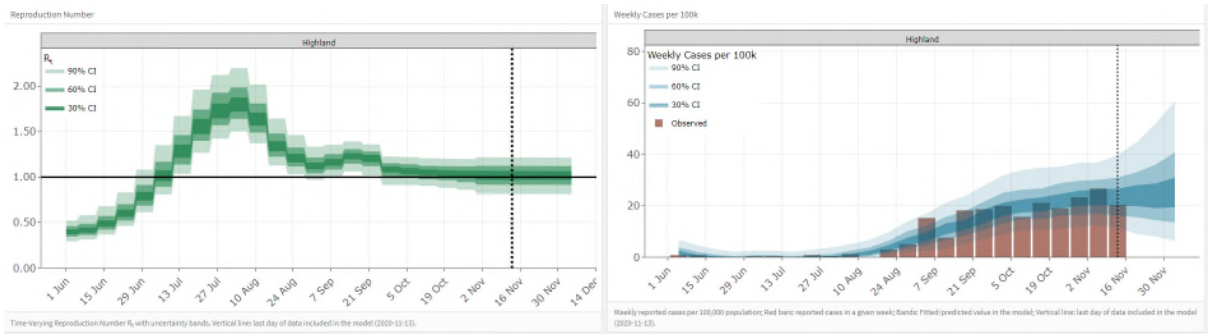
Situation

The population of Highland continues to face significant challenges caused by COVID-19. The level of infection and measures taken to tackle the virus change relatively quickly and the latest picture will be presented at the meeting.

Background

The incidence of COVID-19 in NHS Highland rose after the summer but then levelled off and has shown some evidence of decline. Most COVID infections have been sporadic or part of small clusters and there have been few outbreaks. Management and control of COVID at a personal or local level includes following guidance such as hand hygiene, social distancing, testing and self-isolation by cases and contacts. Actions at the level of NHS Highland include increasing the availability of local testing capacity, provision of additional contact tracers and the management of local cases and outbreaks. The national tiers for community control measures put the Highland Council into an extended tier1.

COVID R Number and Case Tracking and Predictions



A programme of testing for asymptomatic care home staff and specific NHS staff is in place with high levels of coverage. The latest uptake figure for care home staff testing is 92%. The availability of tests for people living in rural areas continues to be a significant challenge. Discussions have taken place with colleagues from Scottish Government and the Scottish Fire and Rescue Service regarding the establishment of a pilot and then wider service provision.

Contact tracing is an important part of COVID control and is most effective when infection levels are relatively low such as the position in NHS Highland. In these circumstances it is possible to get high levels of coverage and so keep virus spread under control. Latest weekly figures for contract tracing performance show that all cases were followed up as were 97% of contacts.

Vaccines have been showing encouraging results in clinical trials. In line with Scottish Government policy, plans for vaccination in NHS Highland are being developed and a draft plan was submitted on 11 November. The start date for vaccination is yet to be determined but it is likely that care home residents and staff, people aged over 80 and health and social care staff will be those offered vaccine first. The vaccination programme will be considerably more complicated than that for influenza and will be a significant logistical and delivery challenge.

The Social Mitigation Action Plan is almost completed. The plan covers the NHS Highland area and so incorporates information from Argyll and Bute. It now covers Highland Alcohol and Drugs Partnership and Violence Against Women to make it a document that represents a wider scope of work.

Engagement work is planned with staff from teams and services identified within the plan.

The main themes captured in the action plan are:

1. Unemployment and the Economy
2. Income and Financial Security
3. Food Security
4. Mental Health and Wellbeing
5. Digital Exclusion
6. Capacity and Community Resilience
7. Transport and Active Travel
8. Violence Against Women

Two examples of progress are set out below:

Members of the Health Improvement Team have been working with the Highland Third Sector Poverty Network to support both the delivery of training on poverty and income and the development of a leaflet which will direct people to where to find help. This is aimed at different community groups and organisations that have supported the provision of food over the pandemic as well as any group or service which provides individuals with support.

The Health Improvement Team have been working on ways to deliver the suicide intervention training (SIPP) using virtual means and have recently organised a session to refresh the current trainers. Training for trainers has also been organised for Caithness and Sutherland to increase the pool of trainers in the North. Plans are in place to deliver the training in the coming months.

Assessment

It is likely that considerable efforts will need to be made over the winter to control sporadic cases, clusters and outbreaks of COVID. Community control measures will be vital in reducing the impact of the virus and will continue to be necessary while vaccination is delivered. The combined effects of successful vaccination, local and national control measures as well as individual actions will be needed to eradicate COVID. Social mitigation measures will need to be in place long after the end of the pandemic.

Recommendation

Members are asked to note the content and implications of this paper and accompanying presentation.

Tim Allison

Director of Public Health and Policy

November 2020

NHS Highland

Meeting	**Highland Health & Social Care Committee**
Meeting date:	**2 December 2020**
Title:	**NHS Highland Adult Mental Health Interim Strategy 2020 – 2021**
Responsible Executive/	**Louise Bussell, Chief Officer**
Non-Executive:	
Report Author:	**Dr Neil McNamara, Clinical Director**
	Fiona Davies, Interim Head of Service

1. INTRODUCTION:

This document supersedes the previous Annual Operating Plan and develops further the mental health service remobilisation plan which has been drafted during the course of the 2020 SARS-Cov-2 pandemic. It describes service operating constraints and necessary actions in the immediate future. It precedes a wider strategic review which we propose is required for the period 2022-2027.

2. NATIONAL POLICY AND GUIDANCE CONTEXT:

In a much changed landscape of mental health service delivery we have identified 3 key contemporary documents which it is important to acknowledge and which provide a set of principles to guide operational decisions.

2.1 Letter to HSCP Chief Officers and NHS/ LA Chief Executives dated 22nd October 2020 from Delayed Discharge Expert Support Group regarding embedding a "Home First" approach

This urges the above named parties to make progress with a number of standards to support effective care planning and discharge "without delay". It asserts that people in general recover better and faster from illness at home and that significant shifts in culture and practice are required to enable this approach to become the aspirational default position. It is noted that areas which have had success in this regard have explicit systems in place (either senior individuals or teams) working across integrated services and acute hospitals, empowered with:

"sufficient authority, knowledge and experience to challenge poor discharge decision making and processes, including the management of risks. They should be able to cut through bureaucratic red tape and ensure there are no valid impediments to

timely discharge home. In addition, they should ensure longer-term sustainability and that delayed discharge be seen as a collective responsibility rather than one person's or one team's."

2.2 "Mental Health – Scotland's Transition and Recovery"

This describes in detail the Scottish Government's proposed response to the impact of Covid 19 on population mental health. As per the existing 2017 – 2027 Mental Health Strategy, it emphasises the importance of building resilience and ensuring that people receive the right support at the right time in the right setting. It speaks of a necessary "renewal" of mental health services with particular attention paid to the pervasive effects of trauma, socio-economic adversity and loneliness, as well as the value of distress interventions, a co-ordinated approach to suicide prevention and a universally trauma informed workforce.

2.3 "Trust and Respect – Final Report of the Independent Inquiry into Mental Health Services in Tayside"

Following widespread concerns raised in the Scottish Parliament in May 2018 about the provision of mental health services in Tayside, an Independent Inquiry was commissioned to examine the accessibility, safety, quality and standards of care provided.

The report identifies significant failings in 5 thematic areas: strategic service design, clarity of governance and leadership responsibility, engaging with people, developing a learning culture and transparent communication with stakeholders.

Within NHS Highland, all 5 themes above are highly pertinent to the challenges that we also currently face in mental health service delivery. That is not to say that there has not been progress, particularly with regard to clinical governance, within the limitations of current structures. However, there are persistent legitimate concerns that the NHS Highland community service model – where vital specialist secondary care community mental health services are under the operational management of numerous generic local district teams – uncomfortably replicates the problems identified in Tayside. Most importantly, this arguably introduces significant unnecessary risks in both accountability and our ability to plan strategically.

The following key extracts from the Tayside report emphasise this issue:

"…The most striking failure of governance of mental health services in Tayside is the lack of a mental health strategy. In the light of the reduction in the availability of consultant psychiatrists and the requirements for providing care and treatment for patients with mental ill health in the community, there is a pressing need for a significant redesign of how mental health treatment and services are to be delivered in the 21st century. There needs to be a strategy to deliver a whole system, end-to-end, multi-disciplinary, radical transformational redesign of mental health services…

…In recent years (and probably for many years prior), too much focus has been placed on short-term issues, to the detriment of long-term strategic planning. Whilst of course there will always be a need to address short-term and urgent issues as they arise, this should not mean that the necessary focus on long-term and strategic issues is neglected. Additionally, there has been too much focus on inpatient services to the detriment of wider community mental health services, where the vast majority of patients are treated…

…Integration arrangements are intended to encourage positive joint working, shared commitments and a common understanding and approach to tackling challenges. In practice, it is apparent that these differing arrangements add complexity to the governance mechanisms and do not aid clear lines of accountability and responsibility, resulting in a fragmentation of services and accountability...

…The responsibility for managing risks is an important element of improving the services. It requires an unambiguous clarity of responsibility. In Tayside there is uncertainty about the processes for risk management and the risks do not sit with people who are able to respond effectively to them…"

3. IMPLICATIONS FOR LOCAL STRATEGIC DIRECTION:

It is some years since a Mental Health Strategy review for Highland was last undertaken. It is essential that any comprehensive strategy should reflect all ages and stages of life and reflect an approach to mental health which meets local needs across our population and geography. Such a strategy would need to be co-produced with those who use services as well as those who care and support them. We recognise that the engagement of these groups is vital to the successful and meaningful production of such an ambitious piece of work.

With this in mind, it is important to emphasise that this document reflects for now the *interim* strategic direction that we are taking to modernise and improve the adult mental health services currently delivered within NHS Highland.

The reality of our current service delivery illustrates starkly those areas that need focussed work to align with the expectations of the Home First approach and the service and governance clarity recommended by the Tayside report. Our challenges are in no small part caused by national shortages of key workforce groups in mental health, particularly consultant psychiatrists and registered mental health nurses. Further challenges arise out of our current operational arrangements which mean within our community services a weekday daytime service only is offered, with no local specialist response to urgent situations out of hours. The shortage of hospital based staff has resulted in sequential pragmatic emergency bed closures, meaning that community investment to support alternatives to admission have not developed in parallel. Mental health patients have experienced significant delays in leaving hospital if additional social care input has been required, with limited options for specialist social care co-ordination and follow up/placement.

Drawing together these strands with the principles emerging out of the documents highlighted in section 2 above, it is clear that there are a number of actions which

need to be taken immediately to ensure safe and effective service delivery and prepare the ground for a future comprehensive review.

4. IMMEDIATE SERVICE STRATEGY, KEY ACTIONS:

4.1 Emergency & Unscheduled Care

We recognise that this is a particular area in which improvements can be made in terms of safe services and equity of access as follows.

4.1.1 Mental Health Assessment Unit

As part of the response to Covid expected by the Scottish Government and in order to reduce unnecessary footfall in A&E, we have been directed to develop a Mental Health Assessment Unit located in our major urban centre (Inverness) which can undertake emergency assessments in an alternative setting whenever it is safe and appropriate to do so. Plans are in place to create this facility in at New Craigs hospital, commencing operation from November 2020. Patients will be referred from police, ambulance, A&E, primary care and the new flow hub. This will provide a 24/7 assessment and advice service, offering face-to-face contact where practical but also remote access via Near Me to remote and rural areas across Highland as required. Lessons learned through evaluation may inform future development of remote access models across the service.

4.1.2 Emergency & Unscheduled Care Practitioners

Recent innovative use of Action 15 funding has seen the creation of Emergency and Unscheduled Care Practitioner posts in Lochaber (x2), Skye (x1) and Caithness (x1) – creating additional capacity for rapid assessment of patients referred from primary care, RGH A&Es and police custody. This has proven successful and it is clear that the model should be expanded to cover all areas across the North & West with sufficient resources to allow 7 day a week working. A pilot is underway in Lochaber to inform the necessary staffing and operating procedures required for this roll-out.

4.1.3 Distress Brief Intervention (DBI)

The DBI model – based on offering immediate access to 14 days of crisis resolution for those presenting with mild to moderate psychosocial difficulties - has been established in the Inverness area with Support in Mind as our partner provider. We have committed to developing an implementation plan with Support in Mind, Scottish Government and other stakeholders to enable availability of this resource across Highland by September 2021.

4.1.4 Psychiatric Emergency Plan/ places of safety

Given the above developments, and prior identified deficiencies in clarity of pathways/ equity of access, there is a requirement to update our Psychiatric Emergency Plan – utilising the framework laid out in the Mental Welfare Commission for Scotland report “A review of Psychiatric Emergency Plans in Scotland” published

in June 2020. In particular there is an urgent need to optimise place of safety arrangements in remote and rural areas.

4.2 Community Mental Health Services

4.2.1 Review of consultant psychiatrist job plans to address shortages

It can be seen from the Tayside report that across Scotland there is a widespread shortage of suitably qualified and experienced consultant psychiatrists which has been recognised for some time. Local experience confirms that since early 2020 we have had particular difficulty recruiting both locum and substantive candidates to apply for vacant posts. Our current functionalised general adult service model requires 8 x community based consultant psychiatrists to work closely with 8 x analogous community mental health teams and associated GPs. We currently have 2 persistent vacancies in this model – cutting right across the north of our geography from Caithness to East Ross – and we anticipate that by early 2021 this number of vacancies will have risen to 4 (50% of posts). This is a similar magnitude of shortfall to that experienced by other boards, including e.g. Grampian, Tayside and Fife. It is a picture also reflected in our own older adult services. This is not sustainable or safe. There is an urgent requirement for a strategic review of general adult and older adult community mental health service delivery and a rapid re-organisation of consultant job plans to allow a focus on cases meeting a higher threshold of severity, complexity and risk over a wider geography than is currently the case.

4.2.2 Associated review of community mental health team composition/staff roles and responsibilities

Following on from the above, where it is identified that money previously allocated to consultant staffing cannot be spent due to recruitment shortages, consideration should be given to investment in enhanced roles for a range of other staff including e.g. Advanced Nurse Practitioners, Consultant Nurses and expansion generally in non-medical prescribing.

Our completed roll-out of PMS activity recording should allow CMHTs to be considered as cohesive entities, including operationalisation of psychiatry, psychology and pharmacy as embedded members of the team rather than separate service lines.

4.2.3 Primary Care mental health services

Recent negotiations have seen agreement reached regarding initiation of tests of change in the delivery of primary care mental health services. Work to identify pilot areas and evaluate models will be commencing early in 2021 in close collaboration with GP colleagues.

4.2.4 Early Intervention in Psychosis (EIP)

The principle which underpins all of the above service change is that of ensuring that the right patient is seen by the right person at the right time. The provision of high quality care to people experiencing psychosis – both at first presentation and

throughout the life cycle – is part of the core business of specialist secondary care mental health services. The principle of early intervention to improve outcomes and reduce long term morbidity is in keeping with all contemporary mental health strategy. Healthcare Improvement Scotland require all NHS boards in Scotland to undertake a needs assessment of scope to deliver evidence based interventions in line with recognised EIP models by the end of this year.

4.2.5 "Stress & Distress" Care Home Liaison Service

Published evidence confirms that a consistent approach to psychosocial interventions for those experiencing agitation in the context of dementia results in improved quality of life, reduced antipsychotic prescribing and reduced overall care costs. A multidisciplinary Care Home Liaison Service has recently been created to support care homes and CMHTs across Highland to implement such approaches in fidelity to the Newcastle model. As part of the review of community provision under 4.2.1 and 4.2.2 above it may be necessary to expand this service further. As well as increasing the likelihood of positive outcomes as per the evidence base the purpose of this strategic intervention would be to maintain patients as far as possible in a domestic setting and reduce as far as possible the demand on necessarily limited in-patient provision (dementia assessment beds).

4.3 Specialist service provision

4.3.1 Summary position

We have well developed specialist provision in the following areas:

- Eating Disorders
- Personality Disorders
- Rehabilitation (most commonly from psychotic disorders, including in-patient and supported accommodation pathways)
- Acute hospital liaison
- Learning Disability (in-patient assessment & treatment unit and community services)
- Forensic services for mentally disordered offenders (in-patient and community pathways)
- Drug & Alcohol Recovery Services
- Mental health services as part of the care and support provided to those in prison and custody

Of note, over recent years significant investment has been targeted at the development of psychotherapeutic interventions for personality disorder and in training staff across Highland in the delivery of relevant/ transferrable group and individual skills. The maintenance of a skilled workforce and the building of population resilience with a shared language for self-management remains part of our overall strategy.

All specialist services highlighted above are essential minimum requirements for a board with the population and geography of NHS Highland and will continue.

Equally, all will also share their part in the comprehensive review of interconnected strategy which is proposed for next year.

The following innovations below are highlighted as being of particular significance.

4.3.2 DARS partnership developments

The Drug & Alcohol Recovery Service are committed to the ongoing partnership work required to reduce drug related deaths in line with the national Drug Related Death Taskforce recommendations and associated work, this includes strengthening prevention work, extending the overdose awareness & Naloxone programme and the local DRD review group.

A pilot of a Harm Reduction Response Unit is planned in partnership with SAS, Police Scotland and DARS. Based in an emergency response vehicle over weekend evenings, the aim is to improve access to the appropriate support and reduce inappropriate presentations for Mental Health Assessment.

4.3.2 CMO Taskforce

The CMO Taskforce priority for developing more robust Sexual Assault & Rape Services to improve individual support and recovery as well as implement the self-referral processes in 2021 is a focussed element of the strategy with a review of current provision and implementation of a responsive model of care following the transfer of the examination suite to NHSH responsibility.

4.4 Psychological Services

Much work has been done to modernise and expand Psychological Services over the last 3 years. We do not have scope within this short, forward facing, interim strategy to detail changes which have already been made. The following items give an indication of some likely areas of development in the immediate future.

4.4.1 Waiting times

As required by Scottish Government reporting targets, Psychological Services have been focussed on the reduction of waiting lists which pre dated the COVID 19 pandemic. Unfortunately the pandemic has set back early progress in this area and work will remain necessarily focussed on the management and reduction of waiting lists for the foreseeable future.

4.4.2 MDT working

Whilst we understand why waiting times require such specific governmental focus, we propose that part of the solution in fact involves Psychological Services staff working as embedded members of multidisciplinary community mental health teams rather than as a separate service – in keeping with the approach described in 4.2.2 above. It is anticipated that this should assist with triaging, signposting, training, supervision and more accessible differentiated delivery of evidence based psychosocial interventions.

4.4.3 Silver Cloud computerised CBT

In terms of differentiated delivery, there has been some success with the implementation of Silver Cloud: a multi-programme online Cognitive Behavioural Therapy (CBT) platform aimed at mild to moderate anxiety and depression. There are additional modules for patients with comorbid long term health conditions, including a programme for Covid-19 related health and social anxiety. Referrals are received direct from primary care and co-ordinated by Psychological Services staff. Early uptake has exceeded expectations and it is likely that additional resource will be required to enable the further planned roll-out of this initiative.

4.5 In-patient Services

4.5.1 Review of Mental Health In-Patient requirements

In-patient services have been historically provided at 2 sites – the vast majority of resource being based at New Craigs Hospital Inverness with a small number of beds for older adults allocated at Strathy Ward, Migdale Hospital.

Whilst Strathy Ward as an environment was indeed purpose built as a dementia assessment ward, the sustainability of attracting and retaining the requisite specialist mental health nursing staff to Migdale Hospital has become increasingly challenging. As a result mental health services are reviewing the best model for delivering older adult mental health services in in-patient and community settings giving due consideration to the model that provides the greatest safe, sustainable and high quality services for this population.

4.5.2 Estates project

New Craigs will continue to provide adult acute admission, intensive psychiatric care (IPCU), rehabilitation, alcohol detox, functional elderly, dementia assessment & treatment and learning disability assessment & treatment beds. Given the complexity of issues around clinical demand, patient flow and provision of a safe environment which meets required standards, a project is in progress to review all aspects of the mental health estate and provide further recommendations to the relevant programme board. Identified workstreams include: bed configuration, use of clinical and office space, ligature reduction, site security and use of greenspace. The project is expected to produce preliminary recommendations by the end of 2020.

4.5.3 Home First co-ordinators

We agree that whilst the Home First approach appears derived primarily to address deficiencies identified in physical health care settings, the underlying principles are also highly relevant to mental health settings and should be applied accordingly. Negotiations are ongoing to secure funding for posts which will act essentially as “Home First co-ordinators” – promoting a progressive approach to discharge planning, removing barriers and reducing lengths of stay by fostering linkages

between health and social care providers. This investment is of the highest priority to address issues with delayed discharges and offset the risks associated with constraints in bed availability which are beyond our control.

4.6 Corporate support and governance issues

4.6.1 Electronic patient record (EPR)

We are not aware of any other mainland board in 2020 which is still so heavily reliant on paper records in mental health services. Numerous Datix reports and adverse event reviews have identified timely communication of accurate patient information as a fundamental requisite for safe and effective patient care. We are of the view that dispersed paper records are a potential barrier to such communication and that a functional EPR, properly implemented, would be a significant step in improving standards. Fortunately, a paper "Helicopter Overview Mental Health Services – Digital eHealth Perspective" published in January 2020 confirms that we have much of the component infrastructure required to create an EPR. These same components have been used successfully by other boards (e.g. Dumfries & Galloway). We submit that the recommendations of the Helicopter Overview should be implemented without further delay.

4.6.2 Public Health/ Planning & Performance support

Our colleagues in these corporate support departments have to date been very approachable and keen to assist us in trying to understand the likely demands on our service in order to plan for the future. However, this resource has to date been constrained. We request that the enormous complexity of data required to make informed strategic changes to mental health services is afforded the appropriate level of priority in order to support the comprehensive review proposed for 2021.

4.6.3 Recruitment, retention and staff development

Whilst the actions outlined in section 4.2 above are essential in terms of ensuring the long term sustainability of the service, nonetheless equal effort should also be made to optimise our approach to staff recruitment and retention. This will require close collaboration with HR and medical staffing colleagues in terms of e.g. our strategy for advertising posts and targeting populations who may be drawn to working in the Highlands. Fundamentally, we also recognise that to attract and nurture staff of the highest quality, it is important for us to provide scope for development opportunities. The Education, Development and Training subgroup of our Mental Health Clinical Governance group has been commissioned to draft a work plan in pursuit of these objectives by April 2021.

4.6.3 Service user and carer involvement

It is hoped that it is clear we seek prominent service user and carer involvement in the development of our strategy for the future. As above, we have set up an explicit Service User and Carer Experience subgroup again as part of our Mental Health Clinical Governance framework. Issues for future consideration include the potential for development of a Recovery College and peer worker roles.

4.7 Child and adolescent mental health services (CAMHS)

At present CAMHS sit outside the remit of this pragmatic interim document. However, in keeping with the principle of early intervention, the desire to develop a cohesive strategy to mental health across the lifespan and the need to optimise interface between services, it is anticipated that CAMHS will form an important component of the large scale strategic review proposed for next year.

6. Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Executive Directors Group – 23 November 2020

Adult Social Care Winter Preparedness Plan 2020-21

Scottish Government
Riaghaltas na h-Alba
gov.scot

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Foreword from Cabinet Secretary for Health and Sport

Every winter brings additional pressures to our health and social care system. But this winter we face those pressures in the midst of the global pandemic of COVID-19. The pressures of responding to COVID-19 and its impact on those who need our services and the frontline staff who provide them with compassion and skill exacerbate too our response to 'normal' winter pressures.

We have learned a great deal so far this year. Significant improvements have been made to the practical delivery of services as our understanding of the virus and how it spreads has deepened and as we try to respond directly to the range of challenges it presents, particularly to those who deliver services and those who receive them. That deepening understanding will continue as we learn more from the work of our clinical and scientific experts and we will continue to focus on delivering clearly and swiftly on all the steps we must take to continue to improve our support and guidance to protect as best we can those who are most at risk of harm from both COVID-19 and the challenges of winter. This will always be about reaching the best balance we can between direct and indirect harm to health and we will work to achieve that balance with all our partners in adult social care.

This Plan sets out the measures already in place that must be retained and those that we believe need to be introduced across the adult social care sector. The Plan aims to be as comprehensive as possible, seeking to offer maximum protection for those who use social care support, whether within residential, community or homely settings, and to those who provide that care, including unpaid carers. It is aimed at mitigating risks likely to arise in the short term and should therefore be treated as a flexible document, which may be updated or supported by additional guidance. At its heart it seeks to provide reassurance that the wellbeing and quality of life of those using and providing social care remains a priority.

Rightly, the plan has been the result of both what we have learned so far this year and close work with our partners. It will also rightly, continue to develop as we respond to developments not only in our shared understanding of COVID-19 but to the continuously emerging development and prevalence of the virus across the country and the challenges that winter presents. I am grateful to the many colleagues and organisations who have contributed to this plan and committed to the work and improvements it outlines.

We will be most effective by working together across the whole range of adult social care services. Collaborative and complementary work will continue and develop across local authorities, social care providers, the voluntary sector, communities, NHS organisations and the Scottish Government. Each must recognise their own clear responsibilities to deliver the services and support needed.

And each of us must continue to listen to those who receive these services, and those who deliver them. Their voice is critical.

Scotland's dedicated social care workforce are on the frontline of our national response to the Covid-19 pandemic. They provide critical support to people across Scotland every day. We have seen the strength of their response, the compassion and care they bring every day to the job they do. Our job is to do all we can to support them.

These are anxious times for all those who use social care support and for their families and friends. Anxious times too for those who work in the sector and their loved ones. Whilst the experience so far this year has taught us a great deal it has also given us a very clear insight into just how difficult this winter could be. I do not underestimate any of that but I know that there is real strength and common purpose across this sector and I know that with our colleagues across the adult social care sector we will continue to pull together to drive the improvements needed and deliver the best we can for our fellow citizens over the coming months.

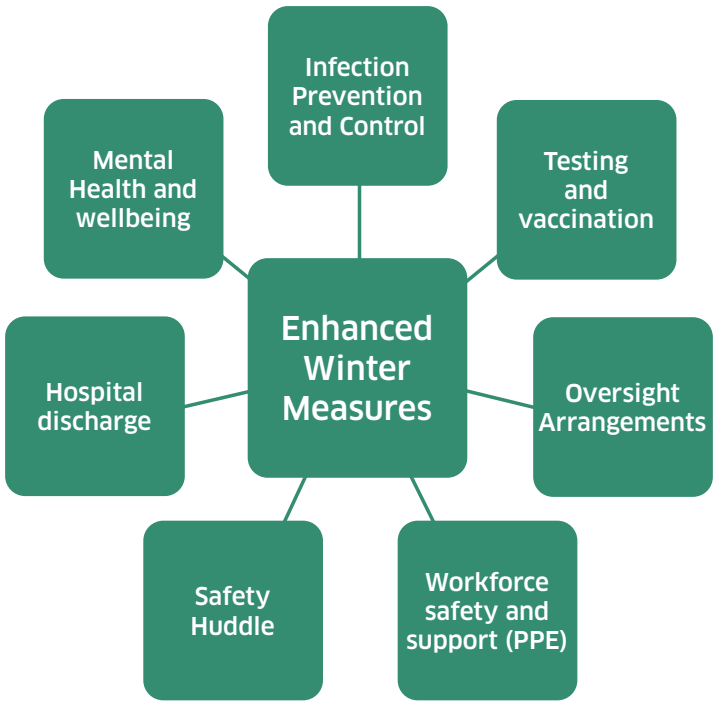
Jeane Freeman

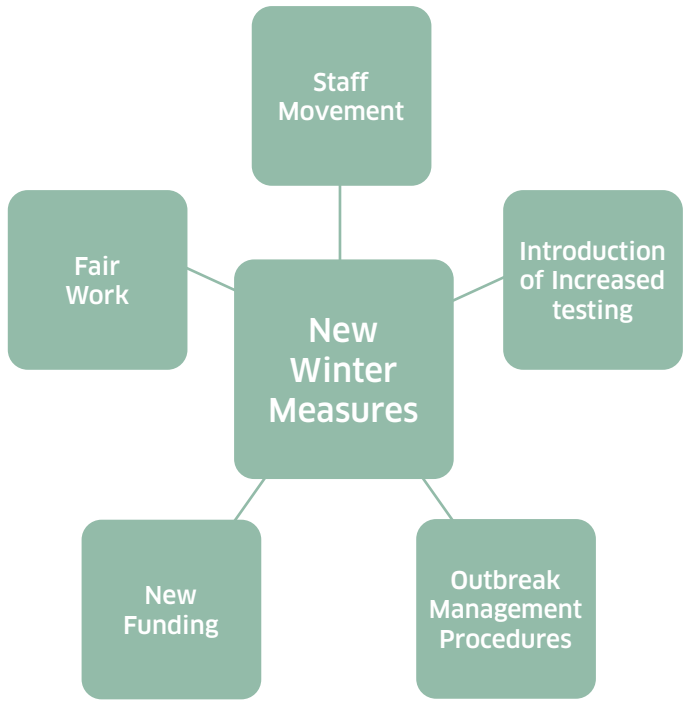
Introduction

The Plan is centred around **four key principles:**

- Learning from evidence to protect people who use social care support from the direct impact of COVID-19, and wider winter viruses.
- Ensuring that people have good physical and mental health and wellbeing, through provision of high quality integrated health and care services.
- Supporting the social care workforce to deliver safe support and care and to have positive mental health and wellbeing.
- Working in collaboration to plan and deliver high quality care.

Within these categories, the Plan provides specific guidance on a range of **critical issues** such as:





The plan **will be delivered** through:

An **evidence paper** is published alongside the plan to provide context and the rationale for our actions. It brings together national and international learning, including the recent publication from Public Health Scotland on discharges from hospital to care homes, and the Root Cause Analysis (RCA) of four sample care homes, also published today.

Context

Adult Social Care is there for people over 18 who need help with day-to-day living because of illness, disability, or older age. It can be provided in many settings, including at home, in care homes or in the wider community. The population receiving social care and support is diverse, with wide ranging needs and circumstances:

- Around 245,000 (1 in 20) people receive social care and support in Scotland.
- Around 60,000 people in Scotland are receiving home care at any one point.
- The majority (77%) of people requiring social care services or support are aged 65 and over.
- People residing in a care home tend to be older, with around 90% of residents aged 65 and over and 1 in 2 aged 85 plus.
- However not all people receiving social care are older. Younger adults with physical and learning disabilities or mental health conditions also receive vital support.
- Poorer health and wider inequalities within any social care cohort will heighten the risk from Covid-19.

Within the context of the lockdown and the wider impacts of the pandemic this year the entire population has faced challenges:

- For the 90,000 people with dementia COVID-19 has presented many challenges for them and their carers.
- For people with autism and learning disabilities the challenges have been magnified.
- It is recognised that people with a sensory impairment and those with communication needs, have faced particular challenges during the pandemic. As a priority, the needs of this group must be considered when they access health care facilities and communications must be available in appropriate language and accessible formats.

The system of adult social care is planned, commissioned and delivered by a wide range of partners. This includes organisations in the public, independent and third sectors. Ultimately the people most critical to the delivery of safe, high quality adult social care services this winter will be those in the front line workforce.

- There were 206,400 people employed in the social service sector in December 2019. There are many more individuals supporting delivery through our multidisciplinary health and social care teams.
- It is also important we recognise the valuable role of unpaid carers with an estimated total of around 690,000 carers living in Scotland, including 29,000 young carers.

This plan was drafted following consultation with a wide range of organisations across the social care sector, including those represented on the Pandemic Response Adult Social Care Group: Local Government, the NHS, Health and Social Care Partnerships, Regulators, the Third Sector, Trade Unions and professional bodies. This Plan will be delivered alongside Scotland's Strategic Framework which set out the methodology for local tiering this winter.

Learning from evidence to protect people who use social care support from the direct impact of COVID-19, and wider winter viruses

The continued provision of high quality adult social care for all services current and future is a priority. Public health measures will be deployed to protect people from the direct harm of all viruses this winter.

Enhanced winter measures:

We have already made significant progress with successful **infection prevention and control** (IPC) practices. These require action by all organisations involved in the delivery of health and social care. It is vital that all staff have the necessary knowledge, understanding and skills to help them continue to improve the overall safety and quality of care. Employers have a duty to safeguard the health and safety of their staff. Services that can safely and effectively be delivered digitally, for example some mental health services, will support reduced transmission. To augment current arrangements the Clinical Professional Advisory Group will lead work for updated IPC in adult residential settings including care homes and community care practice guidance. This will further enhance the existing requirements for all individuals to have a single negative test on admission to residential care settings from the community, requirements for admissions following hospital discharge are covered later in the plan. As highlighted within the Root Cause Analysis (RCA) of 4 sample care homes, this will be accompanied by a dissemination and implementation plan. This will be further enhanced by an additional **£7 million** to enable IPC support and training for adult social care staff led by Health Board Nurse Directors.

The additional risks of COVID to individuals living in a communal setting are now widely understood and the RCA reaffirmed that all care homes are vulnerable to outbreaks. We are now asking providers to introduce a **daily review of COVID symptoms** in care home residents and staff. The Clinical and Professional Advisory Group will shortly provide and issue a checklist of the broader COVID symptoms common to the care home cohort. The pandemic has highlighted that the clinical complexity of people residing in care homes requires significant nursing input. Steps should be taken by partners to increase nursing provision in care homes or, where more appropriate, increase nursing support to care homes.

Vaccinations are the most effective method of preventing infectious diseases. When a safe and effective **Covid-19 vaccine** becomes available at a national level, we will work to ensure that priority is given to: care homes, vulnerable people cared for in their own homes including housing support and residential settings as clinically appropriate, and care workers, paid and unpaid.

The **seasonal flu vaccination** programme remains a key part of our plan to protect the most vulnerable and those at risk people during the pandemic this winter. We are working to secure maximum uptake for all eligible social care workers (including unpaid carers and personal assistants) and for those eligible groups who are in receipt of social care support.

The pandemic has affected every single person in Scotland, including recipients of adult social care. Many of us will have been anxious or worried about our health, our family and friends, and the effect of changes to our way of life. The **Transition and Recovery Plan for Mental Health** has been developed to address emerging evidence and with expert stakeholder input to respond to the current mental health needs of the population: https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/.

Visiting is vital to the wellbeing of residents in residential care and their loved ones and should continue to be supported as safely as possible. It is essential that we achieve a balance between the need for safety and the need for family and visitor contact to address individual feelings of isolation and loneliness. We are actively monitoring the adoption of Stage 3 visiting across Scotland and will work with partners to ensure the consistent adoption of guidance. Essential visits where they will benefit the resident's health and wellbeing, or allow families and friends important time with loved ones in circumstances approaching end of life should be generously and sympathetically accommodated at all-time throughout the pandemic. Visiting arrangement to care homes are updated on the basis of evidence. As at 3 November where the care home is COVID free visiting guidelines recommend 1 designated visitor, indoors for up to 4 hours once a week and up to 6 people from no more than 2 households for one hour once a week. We will also provide further advice and options to opening up care home visiting to support more people to connect with their loved ones where it is safe to do so. To support this further we will expand testing to include designated visitors to care homes as soon as possible. This is likely to involve increased delegation and local ownership and oversight of care home visiting, within a national framework of guidance and principles. This will be supported by local oversight teams and aligned with the new Strategic Framework that supports Scotland's approach to tiering. To improve information and engagement we will shortly publish a website to provide information and advice for families on visiting.

A significant proportion of individuals accessing adult social care support will also fall within the **shielding category**. Information and advice are crucial for those with a higher clinical risk from COVID-19. The national helpline is maintained for people seeking further information or advice about shielding and use of risk assessments is promoted for people who are at high risk and cannot work from home, to ensure their safety. This ensures that they understand the risks, both for their individual condition and of local virus transmission. This supports informed choices about individual protection, particularly over the winter months. Where appropriate, a daily 10 microgram supplement of Vitamin D is recommended to keep bones and muscles healthy, and a free supply is being offered to people shielding in the community. For those in care homes Vitamin D will be recommended on an individual basis, based on clinical assessment.

Our efforts to protect people from the virus and the **rights** of those we are seeking to protect are equally important. Decisions on care must involve the individual as much as possible. Where an individual does not have the full capacity to make decisions, it is critically important that families, guardians and those with Power of Attorney are fully involved in decision making.

New winter measures:

The RCA and the Evidence paper both reinforce that minimising **staff movement** within and between care settings is critical to reducing the risk of transmission. The evidence is clear that reducing the number of people in close contact reduces the risk of infection of COVID-19. Measures to support the adoption of staff cohorts, working in smaller viable units within care homes must be implemented wherever possible. Similarly, in the delivery of care at home and in other settings, staff cohorting or increased continuity of carers should be adopted where possible.

We will explore whether new regulations are required to support this in the coming weeks. However, providers will now be required to demonstrate they have done everything they can to limit staff movement. In addition, agency staff who are asked to support care homes with COVID will be required to self-isolate for 14 days, before moving to another setting. We will keep this requirement under review and update guidance as our knowledge and wider technology develops. Where staff movement is unavoidable it is vital that there is robust recording of all and any staff movement.

The RCA report highlighted the need to ensure sufficient workforce capacity to manage demand and provide continuity of safe care. Implementation will therefore require planning and co-ordination across partners at a local level. We will work with nurse and care agencies, trade unions and wider partners to consider winter staff deployment to support this aim. To support implementation of the requirements to restrict staff movement we will make up to **£50 million** available for care providers. It will be important that every effort is made to ensure any measures do not negatively impact on individual members of this vital workforce.

Testing will remain critical in limiting transmission of COVID-19. The Coronavirus (COVID-19): review of testing strategy sets out our approach to expanding routine testing. Within the priority groups identified are health and care staff who visit care homes, and other residential settings as appropriate; designated visitors to those who live in care homes; and care at home staff. More detail on this is set out later in the Plan.

Ensuring that people have good physical and mental health and wellbeing through provision of high quality integrated care services

A strong and well-functioning integrated system will ensure that people can be supported in the community where clinically possible.

Enhanced winter measures:

Health and Social Care Partnerships must build on the **Home First** approach that has been successful in many parts of Scotland and widely adopted during the pandemic. Strong multi-disciplinary working across health and social care is needed to support a Home First approach, with the NHS supporting a range of Intermediate Care services as well as Hospital at Home. Healthcare Improvement Scotland (HIS) are developing a national learning system to help share knowledge and good practice on Hospital at Home. Resources include:

- Online learning sessions, case studies and podcasts
- Twinning areas developing Hospital at Home to provide peer support and mentoring
- Development of a toolkit to support areas to assess their readiness to adopt Hospital at Home
- Development of standard protocols and templates to help standardise services across Scotland.

Local authorities must balance the COVID transmission risk of restarting some supports and services with ensuring that **social care packages** allow people to live fulfilling lives. The priority is to ensure that eligible care and support needs are being met, in the right way for people and unpaid carers, to ensure safety, dignity and human rights. This includes where care and support needs have changed. We will work with COSLA, Integration Authorities and providers on the scope and mechanisms of additional funding for financial sustainability throughout the winter period to protect social care services In addition, work with Health Boards and Integration Authorities will continue over the coming months to review and further revise financial assessments, and as part of this we intend to make a further substantive funding allocation in January.

Significant work has also been undertaken to ensure that the **NHS 'wraps around'** social care during the pandemic. This has worked well in addressing direct harm from Covid-19 and ensure that non-Covid-19 health harm is addressed. We need to maintain and extend this 'wrap around' more widely for people using adult social care provision. The Clinical and Professional Advisory Group is leading on the development of the care model and this must now be supported into the delivery phase.

There are two aspects to this:

- Ensuring that people stay well for as long as they can; and
- When hospital admission is required, suitable provision is available for people to return to their home with the right support in place, supporting the **Home First** approach.

It will be important to support the acute hospital sector by ensuring no-one is unnecessarily delayed in their **discharge from hospital**. We must ensure that the approach of planning for safe discharge as soon as people are admitted to hospital is adopted across the country. This approach, already shown to be person centred and effective makes sure that when a patient is clinically able to leave hospital they can be safely discharged home or to a homely setting. Packages of care must be appropriate and in place rapidly. Unpaid carers must be involved in the hospital discharge of those they are caring for, ensuring they are able to provide the care required. This approach provides a better outcome for individuals, as well as ensuring hospital capacity is used appropriately.

Public Health Scotland were commissioned to undertake an analysis of discharges from hospital to care homes and their report was published on 28 October. The independent report, produced in partnership with senior clinical and data experts from the Universities of Edinburgh and Glasgow, showed that whilst discharge from hospital, when other factors were considered, did not contribute to a significantly higher risk of a COVID outbreak, discharge along with other factors requires continued improvement and focus. It found the strongest association with outbreaks of COVID was care home size. To ensure that hospital discharge is both safe and effective across the country, in line with the findings of the independent report, Health Boards must ensure that the national testing requirements for people are followed:

Admission of COVID-19 recovered patients from hospital	Patients should always be isolated for a minimum of 14 days from symptom onset (or first positive test if symptoms onset undetermined) and absence of fever for 48 hours (without use of antipyretics). They also require 2 negative tests before discharge from hospital (testing can be commenced on day 8). Tests should have been taken at least 24 hours apart and preferably within 48 hours of discharge. Where testing is not possible (e.g. patient doesn't consent or it would cause distress) and if discharged to care home within the 14 day isolation period, then there must be an agreed care plan for the remaining period of isolation up to 14 days.
Admission of non-COVID-19 patients from hospital	Testing should be done within 48 hours prior to discharge from hospital. A single test is sufficient. The patient may be discharged to the care home prior to the test result being available. The patient should be isolated for 14 days from the date of discharge from hospital. Risk assessment prior to discharge from hospital should be undertaken in conjunction with the care home. Note: an admission to hospital is considered to include only those patients who are admitted to a ward. An attendance at A&E that didn't result in an admission would not constitute an admission.

The way we provide **primary care** has already changed during the pandemic, with increased use of telephone and Near Me assessments to minimise potential transmission of infection through face to face contact. There are still times when a face to face consultation is clinically necessary, and health and care professionals will continue to enter settings such as people's homes and care homes to provide ongoing care and support when required, with appropriate safety measures. District Nurses, Advance Nurse/AHP Practitioners, specialist nurses and AHP's and community mental health teams have continued to provide essential care during this pandemic and will continue to do so over winter months.

Heath and Social Care Partnerships will continue to work closely with community pharmacists, AHPs and community nursing teams to co-ordinate support for care homes and other care settings to ensure good pathways of care and support during any outbreaks. GPs and multi-disciplinary teams lead delivery of care to patients at home with multiple co-morbidity, general frailty associated with age, and those with requirements for complex care. Ensuring the deployment of sufficient resources across the multidisciplinary teams to support compliance is crucial. Health care pathways and more care within the community setting, including urgent care and support for palliative and end of life care over the winter period must be supported. In addition, where possible GPs may wish to consider aligning with a care home local to their practice to offer strategic support to the care home management over the winter months, whilst respecting the individual choice of residents on GP registration.

Oral and Eye Health care underpin the wellbeing of people living in care homes or other at risk groups. During winter 2020/21 the focus will be to continue the safe provision of urgent and essential oral and eye health services, including remote consultations where it is appropriate. Patients will continue to be risk stratified with ongoing support to those in care homes and with additional needs. Service remobilisation also involves availability of key services such as new spectacle prescriptions for failing eyesight, the replacement or repair of dentures and spectacles, and the detection of oral cancer and sight-threatening conditions.

The **Community Pathway** has been in place since 23 March 2020 with symptomatic patients being directed (via NHS24 111) to local Community Hubs for further triage and assessment. As announced in the Programme for Government, the existing Covid Community Pathway will be enhanced to support people over the winter period, as patients present with symptoms similar to COVID-19 symptoms, such as cold and flu. Significant engagement has taken place, and will continue, with key stakeholders – across Primary and Secondary Care – to agree how this model will be delivered at a local level. Public Health Scotland data reports that between 23 March and 8 October a total of nearly 180,000 consultations were carried out with patients being triaged to Community Hubs and Assessment Centres. This includes telephone advice, face-to-face consultations at assessment centres and a small number of other recorded consultation types.

People who may be approaching **end of life** will get the care and support that is right for them. We will support medical professionals to have sensitive and timely conversations with individuals and their loved ones (where appropriate) about their care wishes should there be a risk of them becoming seriously ill. These can be challenging conversations and can reflect the variety of anxieties and concerns people can have during what remains a difficult time for us all. That is why we want to learn from our experiences earlier in the pandemic and adopt a more person centred and sensitive approach to anticipatory care planning (ACP) discussions.

It is important to recognise that in some cases of overwhelming illness, particularly in individuals with significant or multiple pre-existing conditions, some treatments such as Cardiopulmonary Resuscitation (CPR) may not be effective. This can often be a difficult subject to discuss, however it is important for medical professionals to be open and realistic with people and their loved ones, about whether this treatment is likely to be successful given the specific medical circumstances of the individual. However, there is no specific requirement to have a discussion on CPR as part of an anticipatory care planning (ACP) conversation, unless the individual raises this and wishes to discuss it, or the clinician feels strongly that they need to discuss it for the individual's wellbeing.

Our healthcare professionals are trained to have these conversations and will help people, and those closest to them, to make an informed choice about the treatment and care that is right for them. However, we want to build on our learning from earlier in the year and have a range of tools to support clinicians in taking a more person centred and sensitive approach when having these discussions. To aid them in this work, on 30 September 2020, the GMC launched updated guidance on *Decision making and consent*. The updated guidance focuses on person centred care and aligns with the Realistic Medicine agenda in Scotland. It promotes shared decision making as the key to ensuring people receive the treatment and care that they need, based on what matters to them, and ensuring they have all the information they need to give informed consent.

Additionally, resources have been developed to support clinical colleagues in having these conversations in a more person centred, sensitive and holistic way. These are available on the Healthcare Improvement Scotland website https://ihub.scot/project-toolkits/anticipatory-care-planning-toolkit/anticipatory-care-planning-toolkit/

We will also continue to work with health and social care colleagues to ensure that information and guidance to support care planning conversations are easily accessible to the public, medical professionals, and care providers to help ensure that people get the advice they need, when they need it.Our overarching Cardiopulmonary resuscitation decisions – integrated adult policy guidance makes clear that these discussions and decisions should be consistent with relevant legislation and guidance, such as the Human Rights Act (1998), and the Adults with Incapacity (Scotland) Act 2000.

Supporting the social care workforce to enable the delivery of safe support and care and to have positive mental health and wellbeing

Social care employers and Health and Social Care Partnerships will fully support their dedicated social care workforce through these challenging winter months.

Enhanced winter measures:

We will sponsor **fair work** practices by continuing the **Social Care Staff Support Fund**, in addition to the support provided by adult social care employers. This will ensure that staff are paid their expected income when ill or self-isolating as a result of Covid-19 where their terms and conditions pay less than this.

The additional pressures of the pandemic to the delivery of adult social care will have had an effect across the workforce. We recognise that as we enter winter, and after some very challenging months, individual reserves may be low, and people are concerned about future challenges. Supporting the **mental health and wellbeing** of the workforce, the third sector and unpaid carers will be key. We will maintain access to local NHS Board workforce wellbeing services, raise awareness of the health and social care wellbeing national hub PROMIS and the mental health support service at NHS 24.

Through our partners and existing forums we will raise awareness of the Disclosure Scotland Priority COVID Staff process to support the prompt **recruitment and appointment** of additional resource. We will provide access to staff identified through the Health and Social Care Covid-19 Accelerated Recruitment Portals which has enabled those with relevant skills and experience to come forward and support health and social care services. In addition, we will work with care homes to understand the additional administrative activities required in response to COVID.

Local level workforce plans and staff rosters should be reviewed frequently by Health and Social Care Partnerships as part of professional oversight to identify **risk of staffing deficits** and offer advice and/or mutual aid where required. In circumstances where mutual aid is required it will be facilitated in a timely fashion to support safe care where necessary and provide support and sick pay to staff where it is required. Mutual aid across geographical boundaries should also be effected where necessary.

Ensuring our essential social care workforce, and Scotland's unpaid carers, have access to the **Personal Protective Equipment** (PPE) they need in order to carry out their roles safely during the pandemic is essential. Given the immense pressure on normal supply chains due to Covid-19, the Scottish Government, through NHS National Services Scotland has since March 2020, been providing top-up and emergency provision of PPE free of charge. This arrangement will continue until at least the end of March 2021. It will also be enhanced with the dissemination of information and updated PPE guidance for social care providers. This is important for the safety and wellbeing both of those providing care and support and the people they are supporting. Scotland's COVID-19 PPE Action Plan will help ensure that the right PPE of the right quality gets to the people who need it at the right time.

Testing will remain critical in limiting transmission of COVID-19. All care home staff, including agency staff, where they are deployed to care homes,will continue to be offered weekly COVID-19 testing and uptake to date will be sustained by partners. With around one third of tests already moved, we will continue the transition of testing to our NHS run labs by the end of the calendar year, to secure improved turnaround times. The Coronavirus (COVID-19): review of testing strategy presents a clinical and scientific review of our COVID-19 Testing Strategy in light of the latest evidence and sets our priorities for extending testing as soon as capacity increases. This will expand routine testing to health and care staff who visit care homes, and other residential settings as appropriate, such as community nurses. It will further introduce testing for designated visitors to those who live in care homes where this can add an additional layer of risk mitigation and enable safe visiting to continue. Finally, it will allow us to expand testing to care at home staff as soon as the technology and capacity allow. We will also consider the delivery alignment of all new testing provision with local areas with highest community prevalence. Social care staff more widely and those in receipt of social care will continue to get tested if they or someone in their household are displaying symptoms or if they have been advised to be tested as a contact of someone who has tested positive for COVID-19.

Recognising and supporting **unpaid carers** is central to the sustainability of the social care system. The pandemic has thrown into sharp focus the important role that unpaid carers play in our communities. It has also significantly increased the pressures on carers and the numbers of people carrying out unpaid caring roles. Local delivery will be supported by funding and working with partners including the Carer Centre Manager Network and Scottish Young Carer Services Alliance. This will help local services to share practice and resources, and ensure that local carers' services can access tools to support staff to build resilience over the winter months. This winter we will also work, through a dedicated national campaign, to encourage carers to take up the support they need to look after their own health and wellbeing, and to highlight the value of unpaid care and the pressures on carers.

New winter measures:

To develop our **fair work** proposals further we will shortly publish details of retrospective financial support for those within the workforce who were unable to work as they needed to shield at any point between March 2020 and the end of the UK Job Retention Scheme. Eligibility will be where their employer did not access the job retention scheme to furlough them.

Working in collaboration to plan and deliver quality care

The delivery of adult social care in Scotland requires effective collaborative working between planners, commissioners, providers and improvement and protection bodies.

Enhanced winter measures:

In May it was announced that multi-disciplinary enhanced **clinical and professional oversight arrangements** for care homes should be put in place in every HSCP area. This included a daily meeting of the Chief Officer, Chief Social Work Officer, Director of Nursing, Director of Public Health and Clinical Director (or their representatives) to review the position of all adult care homes in their area. The Care Inspectorate are included as appropriate in these considerations. For the 2020/21 winter period, it is expected that these daily huddles will continue to operate. The scope of interest should now be extended to wider adult social care provision to protect services over the winter. It is also expected that ensuring appropriate health and safety procedures are in place is within the remit of the oversight function. As part of this work local partners should support providers to review and update their continuity plans for winter. Provider engagement with the local multidisciplinary oversight team should be sought where there are concerns by no later than the end of November.

The **Turas Care Management – Safety Huddle tool** has been developed to enable a consistent approach to data collection, report staffing decisions and early escalation and warning to enable timely support and intervention. Over the last 2 months providers have demonstrated a high level of commitment to the adoption of the huddle tool and input to the huddle tool will continue to be promoted and supported by all partners. The RCA conclusions have recommended that more proactive monitoring and review of local data will support increased early outbreak minimisation and management. For that reason, ensuring that the huddle tool is being proactively used by all local partners to record, analyse and act upon information must be a priority. Support and training will continue to ensure greater understanding of the functions that support early escalation of concerns over the winter months and beyond.

Effective scrutiny of, and support to, care homes to ensure the safety and wellbeing of residents will continue. The Care Inspectorate will be supported to continue to carry out **scrutiny and improvement** activity during the winter months. As the pandemic continues, this remains a vital mechanism for protecting and improving services for individuals. The role of the Care Inspectorate remains under continuous review to ensure they have the necessary powers to respond to a continually developing landscape. This was demonstrated in the response to the pandemic, when new emergency regulations were introduced to ensure that the Care Inspectorate could act swiftly to protect and promote high quality social care service delivery.

New winter measures:

National and local partners will work at a local level with the public to prevent, contain and manage outbreaks during the winter period. A number of further processes should be adopted this winter:

- In the event of a **suspected** outbreak this winter the HSCP will immediately provide support to care providers.
- Whilst awaiting confirmation of an outbreak providers should be supported by local partners to immediately review IPC processes and brief all staff on the heightened risk.
- Where any single member of staff or a care home resident shows symptoms of COVID, along with testing and self-isolation of the individual(s) concerned, the local Public Health Team should provide immediate advice on whether all staff and residents should be tested and take the necessary action (ie on the same day of symptoms showing)
- All staff and residents (where clinically appropriate) at care home sites should be tested immediately on confirmation of one positive test and the Health Board will prioritise the analysis and communication of test results ideally within the same day.
- Staff not at work on the day an outbreak is confirmed will be required to be tested and receive a negative result prior to returning to work. Local health protection teams should provide advice on additional follow up testing.
- Local oversight teams are to provide support for care homes in managing outbreaks and ensuring continuity of care by providing mutual aid – for example through staffing if the provider is unable to secure sufficient support through normal routes.

National and local partners, including care providers, need to work together to plan and prepare for **EU exit**. At both national and local level, we need to plan for concurrent risks, with the end of the Transition Period on 31 December coinciding with the ongoing Covid-19 pandemic (and potential for further surges) and the impact of winter (including flu and severe weather).

Delivering Our Response

Finance

The Scottish Government has allocated a total of £150 million this year for social care as part of our additional COVID funding to help the social care sector deal with the financial implications of the pandemic.

It is recognised that ensuring winter preparedness this year is going to require additional resources. This Winter Protection Plan will be supported by **further** funding of up to **£112 million**. We will work with COSLA, and wider partners, immediately on effective allocation of this funding through mechanisms that promote additionality of services and value for money. Funding levels will continue to be reviewed to ensure the sector has the support that it needs this winter.

Funding will be allocated broadly as follows:

- **£50 million** to support the additional costs of restricting staff movement across care settings
- **£50 million** for the Social Care Staff Support Fund and winter sustainability funding through to the end of March 2021
- **£7 million** for Health Boards to invest in Nurse Director teams to support increased infection protection and control measures in care settings
- **Up to £5 million** for additional oversight and administration costs associated with responding to the pandemic and outbreak management

Technology and Digital Support

All those within the social care sector should have the digital tools to provide and receive effective, safe social care services and ensure that innovation is maximised. A refreshed digital health and care strategy with a new data strategy across health and care are in development, alongside key partners, to reflect recent developments as a result of Covid-19.

To improve services this winter at a national level we will:

- **Commit £500,000** to ensure all care homes to have access to digital devices, connectivity and support to keep their residents safe through the national Connecting Scotland Programme. We will work to ensure that moving services online reduces inequalities and does not exclude the least advantaged in society from the services they may need the most.
- Publish a **Digital in Care Homes Action Plan** to ensure residents and staff in our care homes can benefit from a range of digital tools and approaches. We will make NHS email accounts available to all Care Homes to provide greater communication and integration of services.
- Look to build upon the success of the use of **Near Me** video consulting by extending its uptake into social care and care homes.
- Roll out a digital tool to support people with Covid19 and its longer term effects to help them manage their condition from home or a homely setting and a clinical assessment tool to enable an early diagnosis of COVID for care home residents following initial testing.

- Support trials of outbound calling for telecare as a model for wide-scale implementation to deliver a more proactive telecare service.
- Work with key partners to develop approaches to keep people safe during the winter, including promoting the new **Purple Alert App** for people living with dementia and those around them, and the new **About Digital and Me** (ADAM) assessment tool to help people keep connected and independent.
- Encourage service commissioners and providers to consider and engage with national programmes on how technical or digital solutions may help to protect residents from COVID-19 and connect them to their loved ones. This includes the use of Near Me, vCreate, mental health support, clinical assessment tool and more.
- Promote working with local Connecting Scotland Lead Contacts who can advise on available support to get people connected.

Shared Values

To monitor the delivery across the strategic priorities this winter we will put in place national arrangements with COSLA, the Care Inspectorate and others. These monitoring arrangements will focus on implementation and will be reviewed by Scottish Ministers and COSLA Leadership on an ongoing basis. A regular report on winter delivery will also be fed into the Mobilisation Recovery Group, chaired by the Cabinet Secretary, to support the requirement for quality integrated care services set out in this Plan.

In addition, we need to work across partners to ensure strong local oversight that takes account of and responds to delivery barriers and challenges – this will be supported through the Pandemic Response – Adult Social Care Group. Where they are identified action should be taken to support timely resolutions. This will be strengthened by a commitment to shared values to ensure that we have the systems and corresponding behaviours to support high quality integrated services for all of those touched by adult social care:

Communication

The Pandemic Response in Adult Social Care Group (PRASCG), jointly chaired by the Scottish Government and COSLA, will meet on a weekly basis for the next 6 months, to act as an early warning for emerging delivery issues and challenges.

The Clinical and Professional Advisory Group (CPAG), whose remit has been extended to cover wider adult social care settings, will also continue to ensure that the policy and advice is translated into robust clinical guidance for the sector.

The Care Inspectorate will continue to review and oversee the quality of care to ensure it meets high standards. Where they find that improvement is needed they will support services to make positive changes to meet the needs, rights and choices of service users.

Cohesion

All partners will approach discussions about challenges over the winter months in a transparent and inclusive way to deliver timely resolutions that prioritise the needs of service users.

Consider and support adult social care interventions in the round and equitably over the winter months to deliver safe and efficient care.

Demonstrate integrity to resolve challenges in a supportive and empathetic manner.

Collaboration

We will explore with partners the development of accessible information about the impact of COVID on services.

Use the Multi-Diciplinary Oversight model to escalate matters that will impact on the care and support of individuals.

Continue to learn from experience and respect and share findings widely to maximise protection measures for people.

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15th October 2020

Dr Paul Davidson / Mr David Park
Joint Chairs NHS Highland Primary Care Modernisation Board

Dear David/Paul

COVID PCIP 3

Highland LMC would wish this letter to accompany the North Highland COVID PCIP 3 submission to the government.

In pursuit of Primary Care Modernisation, we wish to see an increase in pace of change, devolving New Contract resource down to cluster or practice level where needed, to enable delivery of clinical services to patients.

Putting all the contract workstreams into abeyance throughout the initial Covid response has hindered progress towards our shared goals. It leaves Highland GPs and our patients under resourced compared to other Board areas - as we now struggle to meet the demands of Covid.

£900k was underspent by NHS Highland on the PCIP last year, and the LMC has been reassured about the ability of the Board to ringfence these monies going forward.

We wish to comment on the New Contract workstreams in turn:

Pharmacotherapy

This workstream is generally going very well. GPs and patients are benefiting hugely from this service. The cooperative activity here is an exemplar of a healthy partnership between Board officials (Director of Pharmacy/Lead Pharmacist) and GP Sub representatives.

MSK – First Point Contact (FCP) Physiotherapy

The Board's physiotherapy leads and the GP sub reps have worked productively alongside each other, in difficult circumstances. The FCP workstream financial allocations are lower than practices need and want, and there have been concerns from GPs about shifting of secondary care physio waiting lists into daytime FCP work. Failure to release funding has impeded full delivery of the FCP service in one area, and waiting lists for community physiotherapy services have now increased.

Mental Health Workers

This area is causing a lot of frustration to Highland GPs. There has been no provision of any mental health worker in any of the 65 GP practices in North Highland. We also note:

i. Lack of any significant progress in MH workstream despite being a year one priority

ii. Lack of agreement on Action 15 monies to support this workstream

Community Link Workers

This workstream has been well led by Board officials and agreement was reached between the Board and GP sub around directing this service to those practices where registered patients may stand to gain the most. It has, however, been disappointing that no CLWs have been introduced to any GP practice in Highland, with the tendering process delayed due to Covid. It is now anticipated that evaluation of tenders will not occur until January 2021.

Collaborative Workstream

(Urgent Care, Vaccine Transformation Programme, Community Treatment and Care service)

The agreement in Highland to pool the resources from these three workstreams is seen as a necessary means of avoiding staff in new roles from being spread too thinly. It seemed appropriate for GP clusters to be asked to prioritise clinical needs, although this third party (of the tripartite group) is now slowing up the delivery of the workstream and somewhat weakening the democratic GP sub representative role. There is a pressing need to get these three services up and running, with Practices largely viewing themselves as suitable bodies to devolve resource to. We now have an unfortunate situation where two Cluster Quality Leads (CQLs) may essentially find themselves positioned as being a rate limiting step in new contract delivery, an occurrence which the LMC finds unacceptable.

In summary: Pharmacotherapy has delivered well; we need to dramatically increase the pace of delivery of Mental Health, CLW and the Collaborative Workstreams.

Yours sincerely

Highland LMC Chair's Group

Dr Jonathan Ball
Dr Lorien Cameron-Ross
Dr Iain Kennedy
Dr Chris Williams
Dr Al Miles

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**2 December 2020**
Title:	**Chief Officer Assurance Report**
Responsible Executive/Non-Executive:	**Louise Bussell, Chief Officer**
Report Author:	**Louise Bussell, Chief Officer**

1. Purpose

To provide assurance and updates on key areas of Health and Social Care in Highland.

2. Adult Protection

There is recognition that the Adult Protection Committee requires to significantly improve partnership working in respect of:

- Building greater ownership of the Adult Protection agenda across agencies; and
- Strengthening its assurance process, with a particular emphasis required now to re-establish robust auditable processes.

To this end, work is underway to develop a new Sub-Committee structure to progress the Committee's agenda. The first focus for this will be to establish the Quality Assurance Sub-Committee. The Police have committed to lead on this group. Appropriate representation from Health is being sought to complement contributions from Social Work and Third Sector Partners.

3. Home Farm Care Home, Isle of Skye

The previous report to this committee updated that HC-One and NHSH sought to proceed with an intention to ensure delivery of a safe and sustainable service at Home Farm going forward by transferring ownership and operation of Home Farm from HC-One to NHSH, as confirmed by the Cabinet Secretary for Health and Sport on 3 September 2020.

The previous report also advised that arrangements were underway to ensure the necessary governance, legal and practical steps were undertaken to effect a smooth and seamless transition.

Governance arrangements to oversee and progress the necessary areas of work to ensure a smooth and compliant business transfer have been in place since September 2020. These have involved weekly Project Board and twice weekly Project Team meetings, to both oversee and progress detailed actions around the business and property acquisition, employment transfer and a number of operational and practical issues.

The distinct project phases are as noted below:

Phase 1:	Project preparation and mobilisation	Period to 03/09/20	Complete
Phase 2:	Transfer preparation and business acquisition	04/09/20 – 01/11/20	Complete
Phase 3:	Service transfer and improvement	02/11/20 – 31/03/21	In phase
Phase 4:	Business as usual	From 01/04/21	To start

Following approval by the Project Board, the Business Transfer Agreement was subsequently signed on 29 October 2020, with completion taking place on 2 November 2020.

This target date was therefore achieved as intended and the business transferred to NHS Highland on Monday 2 November 2020. NHSH became the registered operator of Home Farm from this date.

The focus of the project is now on Phase 3, this being service transfer and improvement.

This area continues to have regular oversight by the Project Board, chaired by the Depute Chief Officer.

4. Adult Social Care Services Overview

- **Management Team Update**

As notified to the last committee and building on the established structures within Community Services, the Adult Social Care Leadership and Management Team has been strengthened through the creation of the next tier of the leadership structure. This is to ensure appropriate professional leadership, safe, effective social work practice and the delivery of social care services which are fully compliant with regulatory quality standards and legislative requirements.

During November, a number of key Principal Officers are being recruited to ensure we meet our professional standards, legal compliance and reduce risks to service users, staff and the organisation by ensuring improved quality, safety and cost efficiency in Adult Social Care.

The Directorate will cover:

- Commissioning, Contracts and Compliance
- Quality Assurance
- Registered Services
- Social Work and Professional Standards
- Transactions and Income

- **Partnership Agreement/Integration Scheme**

It was previously intended that a successor scheme would be in place by the end of December 2020. This previous intent has been acknowledged by both THC and NHSH as not now possible and the partners have recognised that it would be preferable if the terms of a revised scheme are agreed before the start of the new financial year, which is now the intention. The NHS Board was updated on this position on 24 November 2020 and an update to The Highland Council is similarly intended.

- **Preparedness for Winter Plan for Adult Social Care**

The Scottish Government (SG) published the Adult Social Care Preparedness for Winter Plan 2020-2021 on 3 November 2020. This is the first national Winter Plan for Adult Social Care and reflects the fact that whilst every winter brings additional pressures to our health and social care system, this winter we face those pressures in the midst of the global pandemic of COVID-19.

The plan sets out the measures already in place that must be retained and those that need to be introduced across the adult social care sector. It aims to offer maximum protection for those who use social care support, whether within residential, community or homely settings, and to those who provide that care, including unpaid carers. It is aimed at mitigating risks likely to arise in the short term and is supported by additional funding of £112 million. Clarity on how those additional funds will be allocated is awaited.

Work is progressing to ensure our Adult Social Care Plan addresses all areas as set out in the national plan and, importantly, sits well within our broader NHS Highland Winter Plan.

Attached Appendix 1

- **Care Home Sector Relations / Communication**

As previously updated, since the commencement of the pandemic, the approach and format of provider engagement has changed to more frequent (virtual) contact to enable issues and risks to be raised and addressed. This approach has worked well for both NHSH and provider's, resulting in improved accessibility and increased responsiveness and it is intended that now established approaches will continue. This increased contact enables the sector to provide timely feedback on current issues and responses to changes to government policy, which enables NHSH to better support implementation or escalation.

Current key areas of concern around visiting guidance, the response to the SG ASC winter preparedness action plan and supplier sustainability, particularly relating to voids (empty beds during Covid-19).

- **Provider Sustainability/Financial Support to Sector**

As highlighted to committee previously, Provider Sustainability/Support Relief is a programme initiated by the Scottish Government (SG) in recognition of the significant pressures on the social care sector as a result of the pandemic, which provides for reasonable funding requirements to be supported, where such expenditure is aligned to local mobilisation plans. Payment's totalling approximately £1.6m has already been paid

to date to providers who have had their claims approved through the agreed governance process.

Arrangements are in place to extend existing sustainability support measures into November in line with SG guidance to ensure that providers are not adversely impacted by any changes to these arrangements, plans are being made to ensure that the approach taken continues to be supportive in the current environment.

- **Remobilisation of Day and Residential Respite Services**

NHSH recognises the impact on supported people, carer's, and families who rely on these valued services that have been disrupted during these unprecedented times.

Plans to remobilise building based Adult Social Care Services are advanced: and we adopted a phased approach consistent with the Government Route Map and other service remobilisation plans in NHS Highland.

We recognise that we urgently needed to:

- Restart essential "in-person" services; delivering these safely and flexibly.
- Redesign some elements of service provision to ensure maximum flexibility in how we respond to perceived and assessed needs and in meeting desired outcomes.

To ensure a holistic person centred approach; work is taking place in localities to:

- Revisit assessment and care planning at a personal level to ensure personal outcomes can be delivered safely and sustainably for those in greatest need;
- Support those carers under pressure to ensure our help to them is prioritised and, where necessary, reshaped.

- **Self-Directed Support (SDS)**

In Adult Services we have seen substantial growth in Self-Directed Support Options 1 and 2 (Direct Payment and Individual Service Fund respectively) over the last four years. There has been a slight increase in the numbers accessing an Option 1 over the period of COVID-19. We have continued to focus on raising awareness across our workforce to embed more consistent practice in terms of adopting a "strengths-based approach" and highlighting the importance of good conversations to inform assessments and support options.

Work is also well underway to produce a new SDS Strategy for Highland. Working alongside Social Work Scotland and SDS Scotland, as well as user and carer representative organisations, our aim is to ensure people have choice and control over the social care and support they are assessed as needing.

- **Carers**

It is acknowledged that carer's are providing more support to those they care for over the COVID-19 period. The suspension of many formal and informal services is recognised as presenting a real difficulty to many supported people - and their carers. Given this, we are contacting recipients of residential Respite services -to begin with - to let them know that the possibility of an alternative "short break" may exist for them by using a direct

payment. We recognise the need to be as flexible and creative as possible when considering the range of support options.

5. Influenza Immunisation

Influenza immunisation has been undertaken in a similar way to that in previous years. However, the eligible population has increased and more infection control precautions have been needed because of COVID. General practice has continued to deliver the community part of the vaccination programme and some new models have been used such as large weekend events using venues that offer more space than practice premises. The programme has been well received and has resulted in good uptake. A total of 101,726 NHSH residents have been immunised to date and among people aged over 65 our uptake is 75% of the population compared with 54% for Scotland as a whole. There have been some shortages of vaccine but work with practices and with Scottish Government has been able to mitigate this. Further immunisation is planned for coming weeks.

6. NHS Highland Winter Plan 2020/21

The NHS Highland Winter Plan 20/21 is designed to pull together the key elements which support the resilience of service delivery over the winter pressures period. The intention of this year's plan is to ensure that the remobilisation of key services and delivery of targets associated with these services is achieved (eg elective surgery, waiting times, treatment time guarantee, acute and ICU bed capacity etc) and can be sustained at times of additional system pressures.

This year the plan is designed to incorporate all of these areas plus a number of new aspects of service delivery including the ongoing management of the pandemic response and a number of new key initiatives intended to improve approaches to the management of unscheduled and urgent care provision.

The overall aim of the NHS Highland winter plan is to enhance community care in order to maintain hospital capacity and underpin sustainable delivery of key targets through:

- Admission avoidance
- Timely discharge
- Anticipatory care planning
- Health improvement and prevention
- Organisational and service resilience

An initial draft Winter Plan was presented to the NHS Highland board at its September meeting.

Since that time further development work has been underway as the engagement on the initial draft has taken place through October including ensuring closer links with the previously published Remobilisation Plan and as the organisation has responded to the Scottish Government's Preparing for Winter supplementary checklist and self assessment and will continue by ensuring that the principles and actions identified in the very recently issued Adult Social Care Winter Preparedness Plan are appropriately covered.

Governance for the Winter Planning process is through the organisation's Performance Recovery Board and to the Highland Health &Social Care Committee

7. Primary Care Improvement Plan 3

Attached Appendix 2a and 2b.

8. Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Executive Directors Group – 23 November 2020
- Confirmation received from EDG - 23 November 2020

9. Recommendation

- **Awareness** – For Members' information only.

Covid PCIP 3

Health Board Area: NHS Highland
Health & Social Care Partnership: Highland Health and Social Care Partnership
Number of practices: 65

MOU PRIORITIES

2.1 Pharmacotherapy	**Practices with no access by 31/8/20**	**Practices with partial access by 31/8/20**	**Practices with full access by 31/8/20**	**Practices with no access by 31/3/21**	**Practices with partial access by 31/3/21**	**Practices with full access by 31/3/21**
Practices with PSP service in place	6	59	0	0	65	0
Practices with PSP level 1 service in place	6	59	0	0	65	0
Practices with PSP level 2 service in place	6	59	0	0	65	0
Practices with PSP level 3 service in place	6	59	0	0	65	0

Comment / supporting information
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

The target we have set is to have a delivery model of 1WTE per 5000 patients. This is not yet achieved in any practices, which is why the majority of practices are showing as "partial access". This is likely to remain the same until March 21 but with the expectation that those who have not yet received a service at all will have some service input delivered by then.
Although we are providing (or offering) the whole range of pharmacotherapy tasks in every practice we are in, we are not doing all of it. Examples of that would be acute prescriptions or IDLs - we are not handling every acute script or IDL that the practice deal with because we are not there 9-5, Monday to Friday.

During COVID we have still managed to recruit to pharmacy posts. Delays in recruitment were not related to COVID. During COVID we maintained input to practices, preferably in person or by utilising remote access to practice clinical systems. Establishing remote access will help with future delivery. In practices that are engaged in the process, we took the opportunity during the COVID period to work on increasing serial prescribing. Covid has meant that we had to reduce face-to-face clinical reviews with patients, both ad hoc reviews and planned annual long-term condition reviews. However, in many cases, we were able to conduct reviews with patients remotely, mainly via telephone. Covid did result in us stopping medication review visits to care homes. We are looking to prioritise patients with long-term condition who are overdue a review, based on clinical risk.

2.2 Community Treatment and Care Services	**Practices with no access by 31/8/20**	**Practices with partial access by 31/8/20**	**Practices with full access by 31/8/20**	**Practices with no access by 31/3/21**	**Practices with partial access by 31/3/21**	**Practices with full access by 31/3/21**
Practices with access to phlebotomy service	65	0	0			
Practices with access to management of minor injuries and dressings service	65	0	0			
Practices with access to ear syringing service	65	0	0	Dependent on needs and priorities identified through Collaborative Working	Dependent on needs and priorities identified through Collaborative Working	Dependent on needs and priorities identified through Collaborative Working
Practices with access to suture removal service	65	0	0			
Practices with access to chronic disease monitoring and related data collection	65	0	0			
Practices with access to other services	65	0	0			

Comment / supporting information
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

Approval at Programme Board was given to create a new workstream, Collaborative Working. By pooling the resource that is allocated to CTAC, VTP and Urgent Care we would hope to have greater local impact through economies of scale. A request has been made of clusters to identify the needs and priorities of the practices within their areas, so that these can be built up into fully costed and staffed models that support and benefit each practice.

With the suspension of the modernisation programme due to COVID, the Collaborative Working workstream has only been able to meet for the first time at the beginning of September. There is agreement to have meetings in rapid succession to be able to quickly see progress and for practices to start seeing the benefit of this resource.

2.3 Vaccine Transformation Program	**Practices with no access by 31/8/20**	**Practices with partial access by 31/8/20**	**Practices with full access by 31/8/20**	**Practices with no access by 31/3/21**	**Practices with partial access by 31/3/21**	**Practices with full access by 31/3/21**
Pre School - Practices covered by service	65	0	0			
School age - Practices covered by service	Lead Agency Model. School age vaccinations are delivered by Highland Council Children's Services					
Out of Schedule - Practices covered by service	65	0	0			
Adult imms - Practices covered by service	65	0	0			
Adult flu - Practices covered by service		Some eligible individuals			some eligible individuals	
Pregnancy - Practices covered by service	0	0	65	0	0	65
Travel - Practices covered by service	65	0	0			

Comment / supporting information
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

Tests of Change have taken place to deliver flu immunisation to for over 65s in one practice area, Care Home residents and housebound patients not on a District Nurse caseload. There has been development on an Immunisation Team for the upcoming flu season who will deliver flu vaccines to Care Home residents and staff in 51 out of 68 Care Homes across North Highland. They will also deliver vaccinations to housebound patients not on the district nurse caseload in Inverness. In other parts of the Highland Health and Social Care Partnership, the Community Nursing teams will deliver to these cohorts.

School age immunisations are delivered by Highland Council Children's Services as part of the Lead Agency Model within Highland.

Immunisation for pregnant women are now delivered by Midwifery.

Approval at Programme Board was given to create a new workstream, Collaborative Working. By pooling the resource that is allocated to CTAC, VTP and Urgent Care we would hope to have greater local impact through economies of scale. A request has been made of clusters to identify the needs and priorities of the practices within their areas, so that these can be built up into fully costed and staffed models that support and benefit each practice.

2.4 Urgent Care Services	**Practices with no access by 31/8/20**	**Practices with partial access by 31/8/20**	**Practices with full access by 31/8/20**	**Practices with no access by 31/3/21**	**Practices with partial access by 31/3/21**	**Practices with full access by 31/3/21**
Practices supported with Urgent Care Service	65	0	0	Dependent on needs and priorities identified through Collaborative Working	Dependent on needs and priorities identified through Collaborative Working	Dependent on needs and priorities identified through Collaborative Working

Comment / supporting information
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

Approval at Programme Board was given to create a new workstream, Collaborative Working. By pooling the resource that is allocated to CTAC, VTP and Urgent Care we would hope to have greater local impact through economies of scale. A request has been made of clusters to identify the needs and priorities of the practices within their areas, so that these can be built up into fully costed and staffed models that support and benefit each practice.

With the suspension of the modernisation programme due to COVID, the Collaborative Working workstream has only been able to meet for the first time at the beginning of September. There is agreement to have meetings in rapid succession to be able to quickly see progress and for practices to start seeing the benefit of this resource.

Additional professional services

2.5 Physiotherapy / MSK	**Practices with no access by 31/8/20**	**Practices with partial access by 31/8/20**	**Practices with full access by 31/8/20**	**Practices with no access by 31/3/21**	**Practices with partial access by 31/3/21**	**Practices with full access by 31/3/21**
Practices accessing APP	6	15	44	0	15	50

Comment / supporting information
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

The figures for partial access represent only small operational changes against our target access for these practices. If the calculation was 95%+ of allocation we would see an immediate increase of an additional 5 practices to those with full access.
The remaining practice provision will be dependent on recruitment and would hope that a number of practices with full access by March 2021 will increase but this is not guaranteed.

Service delivery changes due to the COVID-19 pandemic have resulted in clinicians offering telephone or Near Me appointments in the first instance, escalating to face to face consults decided by clinical judgement. In the initial stages of lockdown FCP clinical activity reduced significantly across all practices, this has gradually increased over the past few weeks to near full capacity, an operational average of 90%. Clinicians have been either home based, or practice based depending on both personal and practice circumstances.

2.6 Mental health workers (ref to Action 15 where appropriate)	**Practices with no access by 31/8/20**	**Practices with partial access by 31/8/20**	**Practices with full access by 31/8/20**	**Practices with no access by 31/3/21**	**Practices with partial access by 31/3/21**	**Practices with full access by 31/3/21**
Practices accessing MH workers / support	65	0	0	65	0	0

Comment / supporting information
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

The Mental Health workstream had a relaunch in February 2020 with a workshop of presentations given by a number of different services. Unfortunately, COVID then caused further delay through the focus shifting to management of the pandemic and in the suspension of the modernisation programme. Although this workstream has been identified as a priority, the workstream has only managed to meet once in June 20. There are continued efforts to consider funding input from both the Primary Care Improvement Fund and from Action 15 to support the provision of Mental Health workers within Primary Care. The Mental Health workstream remains a high risk on our risk register due to the delay in progress and for the lack of an identified model of delivery. It is a priority to see this workstream progressed and to generate a model that supports General Practice, which we would hope to see by March 2021 but without greater clarity of the model, it is difficult to judge how many practices might have access by then.

2.7 Community Links Workers	**Practices with no access by 31/8/20**	**Practices with partial access by 31/8/20**	**Practices with full access by 31/8/20**	**Practices with no access by 31/3/21**	**Practices with partial access by 31/3/21**	**Practices with full access by 31/3/21**
Practices accessing Link workers	0	0	0	0	0	0 (29 by 04/05/21)

Comment / supporting information
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

The CLW service will be delivered by a third sector organisation and will focus on practices with the greatest number of patients experiencing socio-economic deprivation. The funding allocated to this workstream would not realise a meaningful benefit of CLW time and input if delivered to all 65 practices. The service will therefore be targeted at 29 practices which were identified based on practice population and deprivation.

COVID has impacted the workstream in being able to deliver stakeholder events. However virtual stakeholder events are being organised and will take place toward the end of November. These events will bring together GP practices that have been allocated CLW resource with local community groups and third sector organisations to raise awareness of the role of CLW's and explore how GP practices and community/third sector groups and organisations can work together with a CLW at a local level. All tender documentation for procuring the CLW service from the third sector are near completion and it is envisaged that the contract will go on the 'Contracts Scotland' website in the next few weeks. The plan is to award the contract early in 2021 with a start date of April 2021. Work has progressed to identify e-health solutions to ensure appropriate links between the CLW service and GP Practices and all data protection issues have been considered and included within contract specifications and e-health considerations.

2.8 Other locally agreed services (insert details)	**Practices with no access by 31/8/20**	**Practices with partial access by 31/8/20**	**Practices with full access by 31/8/20**	**Practices with no access by 31/3/21**	**Practices with partial access by 31/3/21**	**Practices with full access by 31/3/21**
Practices accessing service						

Comment / supporting information
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous projected delivery

Collaborative Working might result in a range of other locally agreed services being designed in collaboration through tripartite arrangements with GP Sub and GP clusters/practices.

2.9 Overall assessment of progress against PCIP

Specific Risks

Identification of e-health requirements when service models are not yet fully developed
Delivery of an equitable service across Highland to all GP Practices
Engagement with Practices and General Public.
Workstreams are at different stages of development potentially resulting in delivery based inequitable resource allocation

Barriers to Progress

Please detail any barriers to progress and what could be done to overcome those barriers.

Geographical challenges - *identify priorities and needs to deliver a model that benefits clusters/practices. Use of remote access to support delivery but not as a replacement of embedded staff and face to face if possible. Work across clusters or groups of practices to see greater resource available.*
Single model not achievable in all workstreams - *Collaborative Working agreed and progressing to develop model based on identified needs and priorities.*
Funding - *Funding should not be a barrier to progress. Project to clearly identify what is required to make claim for further funding when needed.*

Issues FAO National Oversight Group

Funding by 2021 outline by SG may not be sufficient to meet the resources required to deliver the aims of the strategic framework. The changes to superannuation costs reduces the ability to meet the aspirations of the contract offer.
Clarity around what happens after March 2021 is sought, as well as confirmation if phase 1 is to be extended to March 2022.
The agreement to establish Collaborative Working as a new workstream will enable flexibility to use a greater pool of resource in order to deliver equitable services across the Highland Health and Social Care Partnership area. It is not expected that there will be delivery of board-wide models of service.

Health Inequalities

Covid has highlighted existing health inequalities and without mitigation the response to Covid is likely to increase health inequalities. Ministers are keen to see all sectors renewing their efforts on this and will be encouraging all sectors to work together. HSCPs and GPs are already taking significant actions to close the gap. HSCPs are using their position to bring sectors together to help take a whole-system approach to big issues. GPs are playing their part - whether through referrals to services for weight management or smoking cessation, or through outreach to the communities which are hardest to reach and where most inequality is experienced.
Please provide any comments on the impact of Covid on health inequalities and any measures taken to mitigate this impact.

NHS Highland recognises that the consequences of the Covid - 19 pandemic go far beyond the crucial elements of public health and includes the requirement to mitigate the social and economic impact on our population, particularly in relation to those that are most likely to be impacted due to existing inequalities. NHS Highland has developed a Covid - 19 social mitigation strategy and action plan that outlines our commitment to work with partners in the Highland Health and Social Care Partnership and the Argyll and Bute IJB to mitigate against the social and economic impact of Covid - 19. The social mitigation plan is an important part of NHS Highlands recovery plan and covers seven main issues:
1. Unemployment and the economy.
2. Income and financial security.
3. Food security.
4. Mental health.
5. Digital exclusion.
6. Capacity and community resilience.
7. Transport and active travel.
We recognise the strong links to the Primary Care Improvement Plan, particularly in relation to Community Link Workers and Mental Health Workers and will ensure that links are developed between our social mitigation work and implementation of our Primary Care Improvement Plan.

Further Reflections

Please add any other reflections on the impact of the pandemic, for example:
New developments (e.g. IT, services) which were brought in during Covid which support contract delivery and aims.
Any other services / developments which are locally agreed.
Any other general comments.

IT infrastructure was boosted by the requirement for greater access to remote working and the availability of NHS Near Me. Although it is a great tool to help provide continuity of service and additional support, it does not replace the need for practitioners to be working in practice.

Collaborative Working was approved as a new workstream by Programme Board. With the resumption of the Modernisation Programme, the workstream has now been able to meet and to take forward the aspirations of this new workstream to deliver a model that is based on the identified needs and priorities as recognised at a cluster and practice level, within the parameters of the contract offer. We would hope to see quick progress and support of both practices who are ready to move forward at pace and of practices who need greater levels of input to ascertain the priorities that would best meet their needs. It is not necessary to finalise a whole North Highland model before allowing some areas to develop models more rapidly and therefore to start seeing the benefit of the resource that the PCIF can deliver. This might result in a range of other locally agreed services being designed.

Workforce profile

Health Board Area: NHS Highland
Health & Social Care Partnership: Highland Health and Social Care

Table 1: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL headcount staff in post as at 31 March 2018	8	3	0	0	0	0	0	0	0	0	0	0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	13	2	0	0	0	0	0	0	0	2	0	0
INCREASE in staff headcount (1 April 2019 - 31 March 2020)	12	4	0	0	0	0	0	0	0	27	1	0
PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b]	6	5	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	N/A
TOTAL headcount staff in post by 31 March 2022	39	14	0	0	0	0	0	0	0	29	1	0

[a] please specify workforce types in the comment field
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 2: Workforce profile 2018 - 2022 (WTE)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL staff WTE in post as at 31 March 2018	6.0	2.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	9.2	1.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0
INCREASE in staff WTE (1 April 2019 - 31 March 2020)	9.5	4.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	17.6	1.0	0.0
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	5.6	5.0	N/A	N/A	N/A	N/A	N/A	N/A	0.0	0.0	0.0	0.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0.0	N/A
TOTAL staff WTE in post by 31 March 2022	30.3	13.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	19.6	1.0	0.0

[a] please specify workforce types in the comment field
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Comment:

NHS Highland

Meeting:	**North Highland Health and Social Care Partnership**
Meeting date:	
Title:	**Board Risk Assurance Framework – the Strategic Risk Register**
Responsible Executive/Non-Executive:	**Dr Boyd Peters, Board Medical Director**
Report Author:	**Mirian Morrison, Clinical Governance Development Manager**

1 Purpose

This is presented to the Committee for:

- Discussion

This report relates to:

- Annual Operation Plan (in development)
- Government policy/directive
- Legal requirement

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper is to provide an update on the progress with embedding Risk Management across NHS Highland and to update the Committee on the progress with an overall Board Assurance Framework

2.2 Background

Risk Management is a key element of the Board's internal controls for Corporate Governance.

The Audit Committee's provides assurance to the Board that risk management arrangements are in place and risks are managed effectively.

2.3 Assessment

The procedures for risk management need to be revised following an internal audit review, as they were not comprehensively embedded throughout NHS Highland, in a transparent, standardised manner.

As part of this process it was agreed to review all risks on the corporate risk register and on operational unit risk registers that were graded high or very high. From this review, high graded risks would form the Board Risk Assurance Framework – the Strategic Risk Register.

At an extended Executive Directors Group meeting on 10 August 2020, the corporate risk register and risk sitting on operational unit risk registers graded high/very high were reviewed, From the meeting strategic risks were agreed and new risks identified to form a Board Risk Assurance Framework. It was agreed that risks will be linked to the following categories:-

Workforce,
Finance and Performance,
Public Health,
IT and Digital,
Estates and Facilities,
Clinical Strategy and Redesign.

The outcome of this meeting was discussed further at a Board Development Session on 18 August 2020.

At the Board Development Session, each of the Executive Directors gave an overview of the risks they were responsible for and to explain the action that had been taken or was being taken to mitigate the risks.

Agreement was reached by Board Members on the strategic risks, risk level and the Governance Committee that would provide assurance.

2.3.1 Quality/ Patient Care

A robust risk management process will enable risks to quality and patient care to be identified and managed. Assurance for these risks will be provided by the Clinical Governance Committee.

2.3.2 Workforce

A robust risk management process will enable risks to relating to the workforce to be identified and managed. Assurance for these risks is also provided by the Staff Governance Group and where appropriate to the Clinical Governance Committee.

2.3.3 Financial

A robust risk management process will enable financial risks to be identified and managed. Assurance for these risks will be provided by the Finance, Resources and Performance Committee.

2.3 Recommendation

The Board Risk Assurance Framework was presented to the Board meeting in September and approved.

Each of the Governance Committees has been asked to review their risks and to identify any additional risks that should be on their own governance committee risk register. Review of these risks registers will be undertaken on a quarterly basis or as determined by the individual committees.

Papers have been submitted to the Clinical Governance Committee, Staff Governance and Finance, Performance and Resource Committee.

Support for the development of the governance committee risk registers will be provided by the Clinical Governance Support Team.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 Board Risk Assurance Framework – Strategic Risks August 2020.

Board Risk Assurance Framework – Strategic Risks

18 August 2020

WORKFORCE (STAFF GOVERNANCE COMMITTEE)

ID	Description	Risk Owner	Rationale for Current Score and Mitigation	Governance Group	Consequence (current)	Likelihood (current)	Risk level (current)	Rating (current)	Last updated
1	There is reputational and workforce risk in relation to the culture of the organisation. This could impact on recruitment, retention and performance as well as patient confidence in the organisation	Hogg, Fiona Director of HR & OD	The recommendations from the Sturrock review in May 2019 and the more recent A&B review have been incorporated into an improvement action plan which NHS Highland are committed to. Many actions have already been implemented such as Guardian service, Employee Assistance Programme, the Healing Process, roll out of Courageous Conversations and a review requested for our People Processes. An external Culture Advisor has been appointed to oversee the programme and The Culture Oversight Group meet regularly to ensure that progress is being made. This reports to the Staff Governance Committee. Changing the culture will take a period of time and during this there remains a potential for staff not to feel, valued, respected and listened to.	Staff Governance Committee	Major	Likely	High	16	August 2020
2	There is a risk to service delivery due to the age profile of the workforce combined with the inability to recruit and retain the required workforce due to national and local challenges particularly in remote and rural areas and for clinical specialties.	Hogg, Fiona, Director of HR & OD	Detailed and robust workforce planning is essential for the future. New training programmes e.g. the shortened midwifery course, is required to be delivered locally to 'grow our own' in areas of known risk. Detailed analysis of workforce being undertaken regarding speciality specific workforce profiles and average turnover, to enable targeted workforce planning. 'Working longer' sub group to work with managers to ensure support and flexibility for our workforce to be able to remain working longer. Modernising careers workstream in place which includes youth employment agenda (work experience, apprentice pipeline) Service redesign being considered in areas where the service is at risk due to workforce capacity. Recruitment strategy progressing.	Staff Governance Committee	Major	Likely	High	16	August 2020
3	High number of vacancies in trained mental health nursing (including CAMHS) and psychiatric medical posts with an insufficient level of nurse graduates to meet demand.	Hogg, Fiona, Director of HR & OD	Work is being undertaken in scheduled and unscheduled care to consider different roles for service delivery. Service redesign underway with a reduction in beds in ward. Local training programme being progressed with UHI specifically for mental health nursing. PMO workstreams in place for both NMAHP and Medical to support new ways of working and recruiting.	Staff Governance Committee	Extreme	Likely	Very High	20	August 2020

FINANCE AND PERFORMANCE (FINANCE, RESOURCES AND PERFORMANCE COMMITTEE)

ID	Description	Risk Owner	Rationale for Current Score and Mitigation	Governance Committee	Consequence (current)	Likelihood (current)	Risk level (current)	Rating (current)	Last updated
4	There is a risk around the Delivery of Financial Targets in 2020/21 and the knock on impact on the return to financial balance in 2021/22.	Garden, David, Director of Finance	NHS Highland has an underlying deficit of 39.5 million The Board is not expecting to return to balance until year 3, 2021/22. Significant uncertainty around COVID expenditure and funding along with the implications of remobilisation have increased the level of risk in the current financial year Pausing cost improvement work due to COVID will result in slippage of savings programmes. Implementation of the remobilisation plan along with engagement and ownership from clinical and care professionals is crucial to the implementation. lack of resolution of funding gap with The Highland Council FRB remobilised with focus on appropriate workstreams PRB established re-invigoration of grip and control measures to reinforce messages re-engagement with THC and formation of a programme board close engagement with Scottish Govt	Finance, Resources and Performance Committee	Extreme	Likely	Very High	20	August 2020
5	There is a risk that the performance of the health and care system is compromised in remobilisation due to the number of constraints posed by Covid 19, winter pressures and those pressures inherent in the system pre-Covid 19, NHSH is unable to meet national targets.	Dudek, Pam, Deputy Chief Executive	A Performance Recovery Board established that meets weekly to: Drive forward improvement in performance whilst maintaining oversight of the implications of Covid 19 should further waves of activity occur. Support the recovery and maintenance of the scheduled and unscheduled care pathways through surveillance of delays and redesign of patient pathways whilst also looking to incorporate winter planning arrangements. Ensure whole system readiness to deliver high quality patient pathways and excepted levels of performance. Data driven processes in place to ensure close surveillance of the system and 10 workstreams identified within a programme of work to address areas of underperformance linking to redesign. Surveillance of the performance of the mobilisation plan.	Finance, Resources and Performance Committee	Extreme	Likely	Very High	20	August 2020

PUBLIC HEALTH – (CLINICAL GOVERNANCE COMMITTEE)

ID	Description	Risk Owner	Rationale for current score and Mitigation	Governance Committee	Consequence (current)	Likelihood (current)	Risk level (current)	Rating (current)	Last updated
6	The United Kingdom is leaving the EU Single Market and Customs Union, and the transition period ends on 31 December 2020. If there is no settled outcome from upcoming rounds of negotiations between the UK Government and European Union by the end of October, a 'No Deal' exit from the European Union is highly likely.	Tim Allison Director of Public Health	Assess the national planning assumptions when made available against the potential impacts within the organisation. Record the potential risks, impacts and mitigation measures. Ensure escalation measures are in place to address issues where they are required. Ensure learning from EU Exit preparations in 2018/19 is carried forward.	Clinical Governance Committee	Major	Likely	High	16	August 2020
7	There is a risk that there will be poor health outcomes from resurgence of COVID-19 and the effects of seasonal influenza. There is also a risk of significant disruption to services resulting from both disease occurrence and the impact of control measures	Tim Allison Director of Public Health	Considerable work has been undertaken to control COVID-19 through lock down, infection control and testing. The remobilisation plan is designed to balance the return to more normal health services with continued protection against COVID-19. An expanded immunisation programme is planned to mitigate influenza risk and measures will be put in place for COVID immunisation when an effective vaccine is available. Winter planning includes measures to address these risks.	Clinical Governance Committee	Extreme	Likely	Very High	20	August 2020

IT & DIGITAL (FINANCE, RESOURCES AND PERFORMANCE COMMITTEE)

ID	Description	Risk Owner	Rationale for Current Score and Mitigation	Governance Committee	Consequence (current)	Likelihood (current)	Risk level (current)	Rating (current)	Last updated
8	There is a risk regulatory enforcement action and financial loss through fines imposed on the organisation that may amount to 2%-4% of annual turnover or 20 million Euros, whichever is greater, and or financial claims for compensation by data subjects for material or non-material losses (Article 82 EU GDPR). This will mean failure by the organisation to meet its statutory responsibilities to implement and maintain appropriate technical and organisational measures to ensure, and to be able to demonstrate, that the processing of personal data is in accordance with the EU General Data Protection Regulation (Article 24 EU GDPR). The principles of this regulation will remain post Brexit and will be enshrined in updated UK legislation, believed to be the UK GDPR (TBC). This will result in Financial loss, reputational risk and loss of confidence in the organisation by data subjects who may include patients, staff and other stakeholders of NHS Highland.	Dudek, Pam Deputy Chief Executive	Improve compliance with Statutory Mandatory Training (safe information handling module) Review and updating of outdated policies Siro and DPO have been appointed and are in post Response and action plan have been submitted to the internal audit dated April 2019 Self-assessments are currently underway and have already reduced the risk score to 16, this is taken as an average of each of the operational areas risk score which is assessed on return of the GDPR Self-assessment tool. The DPO team are working through the self-assessments and the overall risk score is expected to improve dramatically with one area already achieving a score of 4.	Finance, Resources and Performance Committee	Extreme	Likely	Very High	20	August 2020
9	There is a risk that NHS Highlands ability to deliver normal service could be severely disrupted by a major cyber incident. This is because NHS Highland's increasing reliance on digital solutions to deliver its services. This will result in an increased likelihood of NHS Highland suffering clinical, financial and reputational damage in the event of a significant cyber incident occurring.	Dudek, Pamela, Deputy Chief Executive	A layered security model has been implemented Endpoint devices and servers have operating system patches applied in a scheduled manner Endpoint devices and servers have antivirus software installed and configured to automatically update Secondary care laptops and desktops have been upgraded to Microsoft Windows 10 operating system Microsoft Advanced Threat Protection (ATP) has been installed on Windows 10 endpoint devices NSH Highland firewall infrastructure has been upgraded to improve perimeter security. NHS Highland has taken steps to ensure that our infrastructure meets the minimum baseline security standards required for Cyber Essentials certification. NHS Highland have implemented the Trend Deep Security tool. This tool mitigates disclosed vulnerabilities in out of support operating systems. Outpost 24 Hacker in a Box vulnerability scanner is used to perform scans against the secondary care server estate NHS Highland operates a multi-site server infrastructure to provide digital resilience NHS Highland has implemented a robust commvault backup system	Finance, Resources and Performance Committee	Major	Likely	High	16	August 2020

ESTATES AND FACILITIES - (FINANCE, RESOURCES AND PERFORMANCE COMMITTEE)

ID	Description	Risk Owner	Rationale for Current Score and Mitigation	Governance Committee	Consequence (current)	Likelihood (current)	Risk level (current)	Rating (current)	Last updated
10	There is a risk within a number of our buildings from asbestos used in the original construction of the building. This was used to provide fire proofing on steel construction. Over time this limpet spray deteriorates and could become a problem. There are a number of areas where this is a problem, primarily Raigmore but other older Hospitals as well. Removal of this Asbestos is nigh on impossible, it would require closure of significant areas of our service, for example the entire diagnostic service at Raigmore. If the Asbestos was to significantly deteriorate, we may be forced to close areas until this could be dealt with. This would be for extended periods of time, months not weeks.	Director of Estates, Facilities and Capital Planning	A system to inspect and monitor Asbestos in-situ. Recently successfully trialled a further mitigation measure in the diagnostic corridor where ceiling tiles were removed and encapsulated the Asbestos with a fire retardant membrane. This worked better than expected and is a model to minimise the risk elsewhere. However, this will take months to implement as it requires access to an empty area for at least 3 consecutive days. This will minimise the risk to as low a level as can achieve without complete removal. Experience of Complete removal in an operational building is very mixed as there will be areas that are impossible to access and therefore the result is there will always be a residual risk.	Finance, Resources and Performance Committee	Major	Likely	High	16	August 2020
11	Raigmore Hospital has a High Voltage and Low Voltage distribution system, all other buildings have only Low Voltage Distribution. The Main components of the HV system had manufacturing defects in them, the protection systems were old and inefficient. Electrical systems in a number of our hospitals utilise obsolete Low Voltage electrical distribution equipment. This causes several difficulties in that spare parts are increasingly difficult to source, deteriorating performance means that nuisance trips are more frequent than they need to be, discrimination is difficult to achieve. While these systems continue to pass the required testing programme the current level of investment does not deal with this at all.	Director of Estates, Facilities and Capital Planning	The HV system at Raigmore is currently in the final phase of replacement. By October 2020 this will be replaced with modern fully compliant equipment. The LV inspection regime currently in place demonstrates compliance with the board's obligations, however the likely deterioration in operational performance will mean an increase in nuisance trips and component failures. This is likely to disrupt services increasingly over time. We will also reach a point somewhere were complete replacement of a distribution board is required. On completion of the HV reinforcement works at Raigmore, we intend to invest some of the limited capital in LV infrastructure, replacing boards in an area and then recycling the parts from the board removed. This will allow more time to spread the investment required. However we still do not invest enough in our estate to keep pace with deterioration and the possibility of service disruption remains higher than it should be.	Finance, Resources and Performance Committee	Extreme	Likely	High	20	August 2020
12	Fire compartmentation at Raigmore requires to be brought up to modern standards. This involves refurbishment in each ward, installing sprinklers and upgrading compartments. This programme has completed about 50% of the sleeping accommodation and will deal with Maternity this year but further work is needed in the tower block	Director of Estates, Facilities and Capital Planning	The programme of work needs to be paced at the level of disruption the Hospital can stand. This will need to be factored into the forward operational plans so a decant ward can be maintained to allow this work to proceed. Funding is also needed for the remainder of this work.	Finance, Resources and Performance Committee	Major	Likely	High	16	August 2020
13	Fire Detection Systems across NHSH Highland were all installed in the late 1990's early 2000's and coming to the end of their operational life. While testing indicates they are still fully functional significant investment is needed to replace panels and detectors.	Director of Estates, Facilities and Capital Planning	The systems are regularly tested and continue to perform to the required standard. However, this will not continue indefinitely. Replacement will be required but the current level of investment does not keep pace with the level of deterioration in the estate.	Finance, Resources and Performance Committee	Major	Likely	High	16	August 2020
14	There is a risk that we do not invest enough in our buildings and we are operating many subsystems well beyond their expected lifecycle and inevitably if we continue this practice some systems will break down more regularly disrupting services and some will simply fail. Simply put our estate is to big for the budget we have. There are a number of issues like flat roof replacement that are simply not funded. We have no programme of cyclical investment; most systems are beyond design operating life.	Director of Estates, Facilities and Capital Planning	This risk is mitigated by inspection and maintenance to an extent. However there are a number of issues that can cause significant disruption to services. Flat roof replacement is used as an example, survey and inspection can identify some issues, but the evidence is clear, these need replaced every 20 years, in the last 10 years we have achieved less than 10% of what we should have done.	Finance, Resources and Performance Committee	Major	Likely	High	16	August 2020

CLINICAL STRATEGY AND REDESIGN (CLINICAL GOVERNANCE COMMITTEE)

ID	Description	Risk Owner	Rationale for Current Score and Mitigation	Governance Committee	Consequence (current)	Likelihood (current)	Risk level (current)	Rating (current)	Last updated
15	There is a risk that in the absence of a NHSH Clinical and Care Strategy being in place, that the organisational efforts lack coherence and as such some aspects of business are not fully aligned to a collective organisational goal.	Dudek, Pam Deputy Chief Executive	National policy and direction is coherence through a variety of strategic document Daily correspondence relating to new asks and considerations are received and processed through EDG and SLT NHSH Remobilisation Plan has been established in line with national policy and strategy. NHSH Remobilisation Plan is being assessed by Scottish Government departments to ensure commitments are coherent with national requirements NHSH Remobilisation Plan was developed with inclusion of all department leadership team, Highland Partnership Forum and the Area Clinical Forum and aligned Professional Advisory Groups The DCO has an objective to complete the strategy for NHSH by Dec 2020. DPH is reviewing the strategic needs assessment post Covid peak to ensure needs and service configuration are a match. Project Management Office and approach in place to drive forward redesign, improvement and recovery.	Clinical Governance Committee	Major	Likely	High	16	August

CODE OF CORPORATE GOVERNANCE

HIGHLAND NHS BOARD

Reviewed by:	Board Secretary
Date of Board Approval:	29 September 2020
Next Review Date:	September 2021

Issue no. 1 – Master

CONTENTS

SECTION E – Counter Fraud Policy and Action Plan **P.123**

This section explains how staff must deal with suspected fraud.

SECTION F – Standards of Business Conduct for Staff **P.137**

This section is for all staff to ensure they are aware of their duties in situations where there may be conflict between their private interests and their NHS duties.

INTRODUCTION

INTRODUCTION

1. CODE OF CORPORATE GOVERNANCE

The Code of Corporate Governance includes the following sections:

SECTION A - How Business is organised
SECTION B - Code of Conduct for Board Members
SECTION C - Standing Financial Instructions
SECTION D – Reservation of Powers and Scheme of Delegation
SECTION E – Counter Fraud Policy and Action Plan
SECTION F – Standards of Business Conduct for Staff

It uses best practice in Corporate Governance as set out in the Cadbury, Nolan and other Reports, and guidance issued by the Scottish Government Health Department and others.

The Board reviews and approves the Code of Corporate Governance each year. Sections A to F are as follows:

a) NHS Highland Standing Orders.
b) The Code of Conduct for Board Members
c) Standing Financial Instructions
d) Reservation of Powers and Scheme of Delegation
e) Counter Fraud Policy
f) Standards of Business Conduct for Staff

The Standing Orders are made in accordance with the Health Board (Membership and Procedure) (Scotland) Regulations 2001. Statutory provision, legal requirement, regulation or a direction by Scottish Ministers take precedence over the Code of Corporate Governance if there is any conflict.

2. NHS HIGHLAND BOARD

NHS Highland Board, 'The Board', means Highland Health Board.

The common name of Highland Health Board as an organisation is "NHS Highland".

The Board is a single legal entity, accountable to the Scottish Government Health Department and to Scottish Ministers for the functions and performance of NHS Highland.

The Board will not concern itself with day-to-day operational matters, except where they have an impact on the overall performance of the system.

The Board consists of the Chair, Non-Executive and Executive Members appointed by Scottish Ministers to constitute Highland Health Board. (National Health Services (Scotland) Act 1978 as amended).

Remuneration will be paid as determined by Scottish Ministers to the Chair and other Non-Executive Board Members.

Any member of the Board may, on reasonable cause shown, be suspended or removed or disqualified from membership of the Board in accordance with the Regulations identified in Section 1 above.

A member of the Board may resign office at any time by giving notice in writing to Scottish Ministers to that effect.

The overall purpose of NHS Highland Board is to:

- Review and ensure the efficient, effective and accountable governance of NHS Highland;
- Provide strategic leadership and direction;
- Focus on agreed outcomes;
- Work in partnership with the Highland Council and Argyll and Bute Integration Joint Board to deliver the Strategic Commissioning Plan and associated outcomes.

The Role of the Board is to:

- Provide and improve and protect the health of local people;
- Provide and improve health services for local people;
- Focus clearly on health outcomes and people's experience of NHS Highland;
- Work in conjunction with the Highland Council and Argyll and Bute Integration Joint Board to improve the wellbeing of people who use health and social care services;
- Improve community planning within the Highlands through membership of the Community Planning Partnership;
- Be accountable for the performance of NHS Highland as a whole;
- Involve the public in the design and delivery of healthcare services.

The Functions of the Board are to:

- Set the strategic direction of NHS Highland within the overall policies and priorities of the Scottish Parliament and the Scottish Government, define its annual and longer-term objectives and agree plans to achieve them;
- Delegate functions and related resources to the Argyll and Bute Integration Joint Board in line with legislation (Public Bodies (Joint Working) (Scotland) Act 2014);
- Deliver services as commissioned by the Argyll and Bute Integration Joint Board in line with the agreed Health and Social Care Implementation Strategic Commissioning Plan;
- Approve resource allocation to address local priorities;
- Ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- Oversee implementation and delivery of the Annual Operational Plan;
- Manage the performance of NHS Highland, including risk management, by monitoring performance against objectives and ensuring corrective action is taken when necessary;
- Appoint, appraise and remunerate senior executives;
- Be responsible for the recruitment, and authorise the appointment of, consultants as required under the National Health Service (Appointment of Consultants) (Scotland) Regulation 2009;
- Approve governance arrangements for NHS Highland which the Board will discharge including through the Standing Committees of Audit, Clinical, Staff and Finance, Resources & Performance.

Responsibilities of Members of the Board include:

- Shared responsibility for the discharge of the functions of the Board;
- Exercise independent, impartial judgement on issues of strategy, resource allocation, performance management, key appointments and accountability, to Scottish Ministers and to the local community;
- Responsibility and accountability for the overall performance of NHS Highland.

3. DEFINITIONS

Any expressions to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

The Accountable Officer is the Chief Executive of NHS Highland, who is responsible to the Scottish Parliament for the economical, efficient and effective use of resources. The Chief Executive of NHS Highland is accountable to the Board for clinical, corporate and staff governance. This is a legal appointment made by the Principal Accountable Officer of the Scottish Government. (Public Finance and Accountability (Scotland) Act 2000).

The Act means the National Health Service (Scotland) Act 1978 as amended.

Argyll and Bute Integration Joint Board (IJB) means the legal entity legislated as part of the Public Bodies (Joint Working) (Scotland) Act 2014.

The 2001 Regulations means the Health Board's (Membership and Procedure) (Scotland) Regulations 2001.

The 1960 Act means the Public Bodies (Admission to Meetings) Act 1960, as amended.

The Joint Working Act means the Public Bodies (Joint Working) (Scotland) Act 2014.

Highland NHS Board comprises 17 Non Executives Directors and 5 Executive Directors, all appointed by Scottish Ministers. Four of the Non Executive Directors are stakeholder members. The Chair and 12 other Non Executive Directors are recruited through an open public appointment process.

Board Secretary is responsible for ensuring that the Board complies with relevant legislation and governance guidance. The Board Secretary will ensure that meetings of the Board of Directors and its Committees run efficiently and effectively, that they are properly recorded and that Directors receive appropriate support to fulfil their legal duties.

Budget means a financial resource proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Board.

Chair means the person appointed by the Scottish Ministers to lead the Board and to ensure it discharges its responsibilities as determined by Government Ministers. The expression 'the Chair of the Board' is deemed to include the Vice-Chair of the Board if the Chair is absent from the meeting or is otherwise unavailable. The Chair of a Committee is responsible for fulfilling the duties of a Chair in relation to that Committee only.

Chief Executive means the Accountable Officer of NHS Highland.

Committee means a Committee established by the Board, and includes 'Sub-Committee'.

Committee Members are people appointed by the Board to sit on or to chair specific committees. All references to members of a committee is as 'member' and when the reference is to a member of the Board it is 'Board Member'.

Contract includes any arrangement including an NHS Service Level Agreement.

Co-opted Member is an individual, not being a Member of the Board, who is appointed to serve on a Committee of the Board.

Director of Finance means the Chief Finance Officer of the Board.

Executive Directors Group (EDG) is the executive arm of NHS Highland Board. Members of the EDG are the Chief Executive, Deputy Chief Executive, Medical Director, Director of Finance, Director of Estates & Capital Planning, Director of Nursing, Director of Human Resources and Organisational Development, Director of Public Health, Chief Officer (North Highland) Chief Officer (Acute Services) Chief Officer (Argyll and Bute IJB).

Health & Social Care Integration (H&SCI) means the strategic direction by Scottish Government given to Statutory Organisations (Argyll and Bute Council, Highland Council and NHS Highland) for the provision of integrated services across health and social care in Highland.

Meeting means a meeting of the Board or of any Committee.

Member means a person appointed as a Member of the Board by Scottish Ministers, and who is not disqualified from membership. This definition includes the Chair and other Executive and Non-Executive Members (Health Boards Membership and Procedure (Scotland) Regulations 2001).

Motion means proposal.

Nominated Officer means an officer charged with the responsibility for discharging specific tasks within the Code of Corporate Governance.

Non-Executive Member means any Member appointed to the Board in terms of the 2001 Regulations and who is not listed under the definition of an Executive Member above.

Officer means an employee of NHS Highland.

Scheme of Integration means the Health and Social Care partnership agreements with the statutory organisations (Argyll and Bute Council, Highland Council and NHS Highland) for the delivery of delegated functions.

Scottish Government means the Scottish Government and is its legal name. All references in this document are to the legal name.

SOs means Standing Orders.

SFIs means Standing Financial Instructions.

Strategic Commissioning Plan means the Health & Social Care Integration Strategic Commissioning Plan as agreed by the Integration Joint Board.

The Code means the Code of Corporate Governance.

Vice Chair means the Non-Executive Member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

4. CORPORATE GOVERNANCE

Corporate Governance is the term used to describe our overall control system. It details how we direct and control our functions and how we relate to our communities and covers the following dimensions:

- Community focus and communication
- Service delivery arrangements
- Structures and processes
- Risk management
- Systems of internal control
- Standards of conduct

NHS Highland Board is responsible for:

- Giving leadership and strategic direction
- Putting in place controls to safeguard public resources
- Supervising the overall management of its activities
- Reporting on management and performance

5. CONDUCT, ACCOUNTABILITY AND OPENNESS

Members of the Board are required to comply with the Members' Code of Conduct and the Standards of Business Conduct for NHS staff.

Board Members and staff are expected to promote and support the principles in the Members' Code of Conduct and to promote by their personal conduct the values of:

- Public service
- Leadership
- Selflessness
- Integrity
- Objectivity
- Openness
- Accountability and stewardship
- Honesty
- Respect

6. UNDERSTANDING RESPONSIBILITIES ARISING FROM THE CODE OF CORPORATE GOVERNANCE

It is the duty of the Chair and the Chief Executive to ensure that Board Members and staff understand their responsibilities. Board Members shall receive copies of the Code

of Corporate Governance. The Code of Corporate Governance is made available to the organisation via electronic means on both the internal intranet and external website. Managers are responsible for ensuring their staff understand their responsibilities.

7. ENDOWMENT FUNDS

The principles of this Code of Corporate Governance apply equally to Members of the Board who have distinct legal responsibilities as Trustees of the Endowment Funds.

8. ADVISORY AND OTHER COMMITTEES

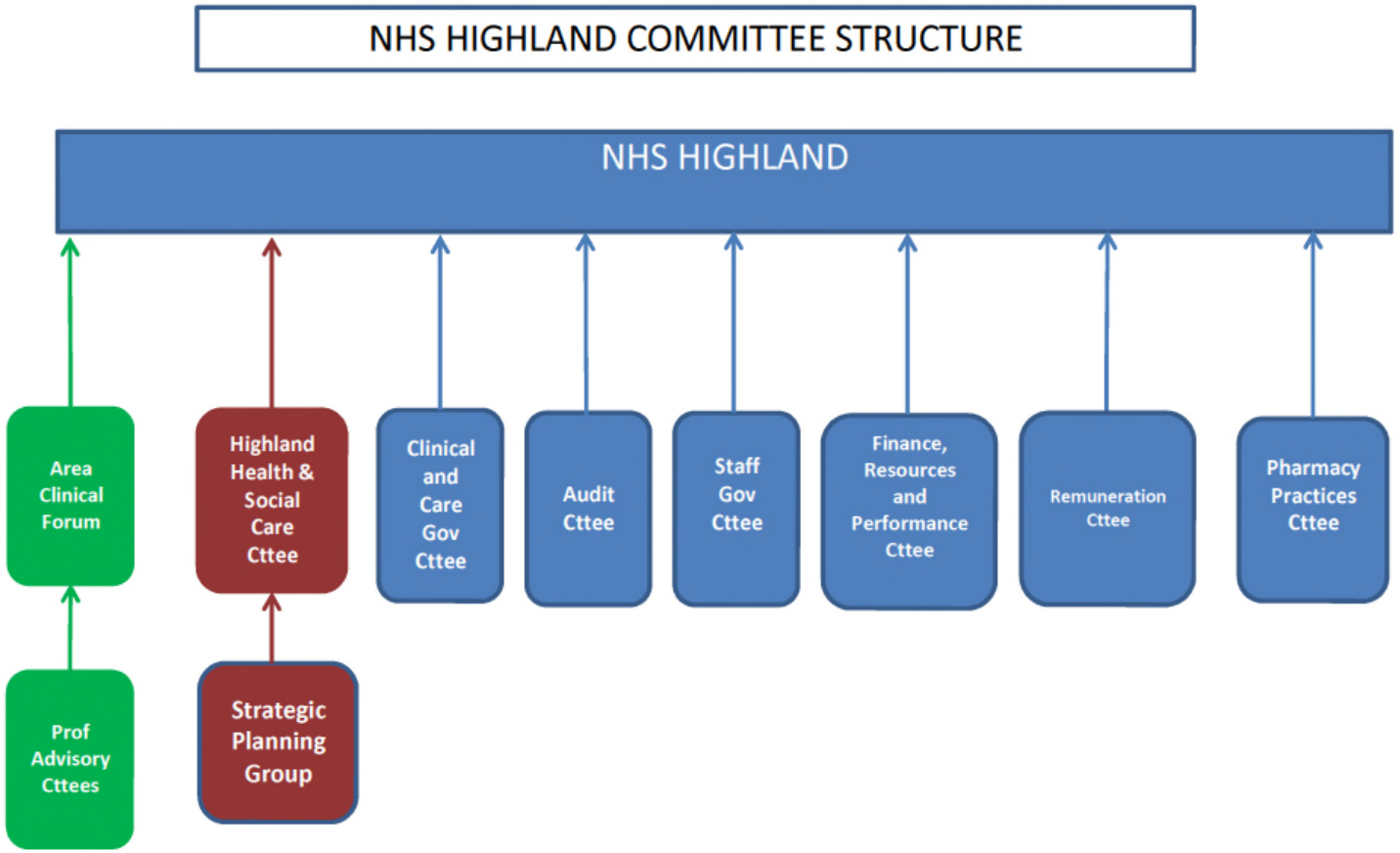
The principles of this Code of Corporate Governance apply equally to all Board Advisory Committees and all committees and groups which report directly to a Board Committee.

9. REVIEW

The Board will keep the Code of Corporate Governance under review and undertake an annual review. The Board may, on its own or if directed by the Scottish Ministers, vary and revoke Standing Orders for the regulation of the procedure and business of the Board and of any Committee. The Audit Committee is responsible for advising the Board on these matters.

SECTION A

How business is organised


NHS HIGHLAND COMMITTEE STRUCTURE
NHS HIGHLAND
Area Clinical Forum
Prof Advisory Cttees
Highland Health & Social Care Cttee
Strategic Planning Group
Clinical and Care Gov Cttee
Audit Cttee
Staff Gov Cttee
Finance, Resources and Performance Cttee
Remuneration Cttee
Pharmacy Practices Cttee

NHS HIGHLAND
STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF HIGHLAND HEALTH BOARD

1 General

1.1 These Standing Orders for regulation of the conduct and proceedings of NHS Highland Board, the common name for Highland Health Board, [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).

Healthcare Improvement Scotland and NHS National Services Scotland are constituted under a different legal basis, and are not subject to the above regulations. Consequently those bodies will have different Standing Orders.

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 NHS Highland. 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 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 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.

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 theirs, 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.

Decision-Making

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

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

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

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

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

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

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

Board Meeting in Private Session

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

- The Board is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation.

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

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

Minutes

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

5.25 The Board 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: 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:

https://www.nhshighland.scot.nhs.uk/Publications/Documents/Standing%20Financial%20Instructions.pdf

and the Scheme of Delegation:

https://www.nhshighland.scot.nhs.uk/Meetings/Documents/Scheme%20of%20Delegation%202013.pdf.

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 NHS Highland Board and is not to be counted when determining the committee's quorum.

Section A

TERMS OF REFERENCE FOR BOARD COMMITTEES

AUDIT COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board approval: September 2020

1. PURPOSE AND ROLE

1.1 To ensure the management of the Board's activities is in accordance with the regulations governing the NHS in Scotland that an effective system of internal control is maintained and that a strong corporate governance culture is in operation. The duties of the Audit Committee shall be in accordance with the Scottish Government Audit & Assurance Handbook, dated March 2018.

1.2 To approve and monitor the delivery of the internal audit plans.

1.3 To ensure a system of internal control is in existence and maintained to give reasonable assurance that assets are safeguarded; waste or inefficiency is avoided; risk management is in place; reliable financial information is produced.

1.4 To support the Board and Accountable Officer in their responsibilities through a process of constructive challenge which focuses on both processes and outcomes.

2. COMPOSITION

2.1 The membership of the Audit Committee will be:

- Five Non-Executive members of NHS Highland Board (one of whom will be the Chair).

2.2 The Committee may have the option to co-opt members to meet specific skill sets.

2.3 The Chair of NHS Highland Board cannot be a member of the Committee.

2.4 In order to avoid any potential conflict of interest, the Chair of the Audit Committee shall not be the Chair of any other governance Committee of the Board.

2.2 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Chief Executive
- Director of Finance
- Chief Internal Auditor or representative
- Head of Area Accounting
- Statutory External Auditor
- Board Secretary

2.3 The Director of Finance shall serve as the Lead Officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive members are present. There may be occasions when due to the unavailability of the above Non-Executive members, the Chair will ask other Non-Executive members to act as members of the committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 There will be a minimum of 5 meetings a year one of which is specifically to consider the annual accounts. Ad hoc meetings to consider particular issues or business requiring urgent attention can be arranged.

4.2 The June meeting will be attended by the External Auditor, and the Annual Accounts will be presented for agreement at this meeting.

4.3 The agenda and supporting papers will be sent out at least one week before the meeting. Papers are made available to all Non Executive Directors of the Board who may attend meetings as they wish.

4.4 NHS Highland Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, the Vice Chair shall chair the meeting.

4.5 At least once per year the Committee should meet with the External/Internal Auditors without any Executive Directors or Board staff present.

4.6 The Committee may sit privately without any non-members present for all or part of a meeting if they so decide.

5. REMIT

5.1 The main objective of the Audit Committee is to support the Accountable Officer and NHS Highland Board in meeting their assurance needs. This includes advising the Board and Accountable Officer on:

- The strategic processes for risk, control and governance and the Statement on Internal Control
- The effectiveness of the internal control environment
- Assurances relating to the corporate governance requirements of the organisation
- Determining the planned activity and results of internal audit reviews and reports
- The adequacy of management response to issues identified by all audit activity, including the external audit's management letter/report
- The accounting policies, the accounts and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of errors identified and management's letter of representation to the external auditors
- Anti-fraud policies, whistle-blowing processes and arrangements for special investigation
- To support organisational and financial performance and efficiency as well as the effectiveness and quality of services

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information required from any employee and all employees are directed to co-operate with any requests made by the Committee. Independent external advice can be accessed in respect of matters within the Committee's Remit.

6.2 The Committee will report to the Board through the issue of Minutes, by highlighting any key issues to the Board and through the Annual Report which will summarise its conclusions from the work it has done during the year.

6.3 The Chair is responsible for ensuring there is clarity of communication and accountability with the other Governance Committee Chairs.

6.4 A self assessment of the performance of the Audit Committee will be undertaken annually and reported to the Board and the Accountable Officer.

6.5 The Committee will work closely with the Audit Committee of the Argyll & Bute Integrated Joint Board, but it is important to recognise the boundaries between the two Committees and the need to avoid duplication. It will therefore be important to ensure the internal audit plans for the two Committees complement each other rather than duplicate effort. The Committee will seek regular updates from the IJB's Audit committee in order to be aware of issues that require its attention and also to guard

against duplication.

7. REPORTING ARRANGEMENTS

7.1 The Audit Committee reports directly to NHS Highland Board on its work. The Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 The Audit Committee will advise the Scottish Parliament Public Audit Committee of any matters of significant interest as required by the Scottish Public Finance Manual.

CLINICAL GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: September 2020

1. PURPOSE

1.1 To carry out the statutory duties as outlined in NHS MEL(1998~)75, NHS MEL (2000)29 and NHS MEL (2001)74.

1.2 To give the Board assurance that clinical and care governance systems are in place and working throughout the organisation.

1.3 To provide assurance that decision making about the planning, provision, organisation and management of services which are the responsibility of the Board takes due cognisance of the quality and safety of care and treatment.

1.4 To support the development and implementation of a Clinical and Care Strategy which fits with national strategies, takes into account local population needs and demographics, and is geared towards quality, sustainable community and acute services.

2. COMPOSITION

2.1 The membership of the Clinical Governance Committee will be:

- 4 Non Executives Board members, one of whom would Chair the committee
- Chair of the Area Clinical Forum
- Staff side Representative
- 2 public/lay members
- Medical Director
- Director of Public Health
- Nurse Director

2.2 Ex Officio

Board Chair
Chief Executive

2.3 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. Where appropriate, deputies will be permitted. In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Deputy Medical Director (Community)
- Deputy Medical Director (Acute)
- Associate Medical Director NH
- Associate Medical Director A&B
- Chief Officer NH/Director of Community Services
- Chief Officer A&B
- Chief Officer of Acute Services
- Clinical Director of e-Health (Head of e-Health as substitute)
- Director of Pharmacy
- Board Clinical Governance Manager
- Clinical Governance Manager Argyll & Bute
- Contracted Services Representative, The Highland Council
- Associate Director Allied Health Professionals
- Head of Midwifery
- Director of Adult Social Care
- Lead Doctor for Child Protection

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least one third of members are present including two Non-Executive Directors.

4. MEETINGS

4.1 The Clinical Governance Committee shall meet as necessary to fulfil its purpose but not less than six times a year. The Chair may convene ad-hoc meetings to consider business requiring urgent attention.

4.2 NHS Highland Board shall appoint a Chair who shall preside at meetings of the Committee and a Vice Chair who will chair in their absence.

4.3 If the Chair is absent from any meeting of the Committee, the Vice Chair shall chair the meeting.

4.4 The agenda and supporting papers will be sent out at least five working days before the meeting.

4.5 The agenda will comprise matters arising, emerging issues and items grouped under the 3 quality ambitions i.e. patient centred, patient safety and clinical effectiveness.

4.6 Items will be added to the agenda with the agreement of the Chair and/or

Medical Director.

4.7 An action plan will be produced after each meeting within 5 working days to ensure business of the Committee is progressed and implementation of agreed actions takes place as soon as possible where appropriate.

4.8 All papers received by the Committee will be presented in person, unless otherwise agreed by the Chair.

5. REMIT

5.1 The remit of the Clinical Governance Committee is to:

- To interrogate the clinical and care governance systems to ensure that the principles and standards for clinical governance are being implemented.
- To challenge evidence gathered across the organisation to raise areas of concern, ensure that these are properly addressed, and to monitor and review the effect of actions taken and report outcomes to the Board.
- To review outcomes against local and national standards and to ensure compliance with national regulatory and performance requirements.
- To select clinical quality targets and outcomes and ensure an appropriate audit and reporting framework is adhered to across the organisation.
- To receive exception reports from its reporting committees on relevant areas of concern and the submission of action plans of amended practice.
- To receive reports from its reporting committees.
- To receive regular reports from the Quality and Patient Safety Groups on the implementation of the quality & patient safety framework and on an agreed range of quality targets and outcomes.
- To receive a clinical risk register on a quarterly basis for consideration by the Committee.

5.2 The Committee is also required to carry out a review of its function and activities and to provide an Annual Report incorporating a Statement of Assurance. This will be submitted to the Board via the Audit Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit Committee in June.

5.3 The Committee shall draw up and approve, before the start of each financial year, an Annual Work Plan for the Committee's planned work during the forthcoming year. This will and will form the annual report to the Board.

5.4 The Committee will agree a range of clinical targets and outcomes in conjunction with clinicians and other relevant personnel and ensure an appropriate audit and reporting framework is adhered to across the organisation.

5.5 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

6. AUTHORITY

6.1 The Committee is authorised to investigate any activity within its remit. It is authorised to seek any information required from any employee and all employees are directed to co-operate with any requests made by the Committee. Furthermore, independent external advice may be accessed in respect of matters within the Committee's remit.

6.2 The Committee is accountable to the Board and will report to the Board through the issue of Assurance Reports. The Committee will raise specific issues with the Board as it considers necessary.

6.3 The Committee will present an annual account to the Board in execution of its duty to provide assurance that NHS Highland's statutory duties with regard to clinical governance are being fulfilled.

6.4 An assessment of the performance of the Committee will be undertaken annually.

6.5 A number of committees and groups are accountable to the Clinical Governance Committee and will provide assurance to the Committee. Such assurance is given by the submission of annual reports of activity and areas of good practice, exception reports on areas of concern, and work plans. Areas of concern identified by these committees will be addressed specifically on the agenda of the Clinical Governance Committee. In addition, the Lead Executives for the reporting Committees will be asked to give a written exception report when appropriate together with an annual presentation to the Clinical Governance Committee.

6.6 Assurance regarding Adult Social Care Services is within the remit of the Argyll & Bute Integrated Joint Board and the Highland Health and Social Care Partnership.

7. REPORTING ARRANGEMENTS

7.1 The Clinical Governance Committee reports directly to NHS Highland Board on its work. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 Committees reporting to the Clinical Governance Committee include:

- NHSH Quality and Patient Safety Groups
- Argyll and Bute Clinical & Care Governance Committee
- Control of Infection Committee
- Information Assurance Group
- Area Drug & Therapeutics Committee
- Transfusion Committee
- Organ and Tissue Donation Committee

FINANCE, RESOURCES AND PERFORMANCE COMMITTEE ROLE AND REMIT

Approved by NHS Highland Board September 2020

1. PURPOSE

1.1 The purpose of the Committee is to keep under review the financial position and performance against key finance and non-financial targets of the Board, and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that the arrangements are working effectively.

2. ROLE

2.1 To scrutinise the overall performance of NHS Highland across the following functions of the NHS Board:

- Resource allocation;
- Performance management;
- Strategic planning.

2.2 To ensure that systems and procedures are in place to monitor, manage and improve performance, across the whole system, and liaise closely with relevant Governance Committees (Staff, Clinical and Audit) to ensure appropriate remedial action takes place.

2.3 To consider financial plans, and approve annual budget proposals and business cases for submission to the NHS Board.

3. COMPOSITION

2.4 The membership of the Finance, Performance and Resources Committee will be:

- Four Non-Executive members (one of whom will be the Chair).
- Chief Executive
- Director of Finance
- Medical Director
- Director of Public Health
- Director of Nursing

3.1 The Chair of the Audit Committee will not be a member of the Finance, Performance and Resources Committee.

3.2 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Deputy Chief Executive
- Chief Operating Officer (Acute Services)
- Chief Officer, Argyll and Bute IJB
- Chief Officer, North Highland
- PMO Director
- Board Secretary

3.3 The Director of Finance shall serve as the Lead Officer to the Committee.

4. QUORUM

4.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive members are present. There may be occasions when due to the unavailability of the above Non-Executive members, the Chair will ask other Non-Executive members to act as members of the committee so that quorum is achieved. This will be drawn to the attention of the Board.

5. MEETINGS

5.1 The Committee shall meet as necessary to fulfil its remit but not less than six times per year.

5.2 NHS Highland Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, the Committee Vice Chair will preside at the meeting. In the absence of both the Chair and the Vice Chair, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

5.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

6. REMIT

6.1 The Committee shall have accountability to the Board for ensuring that the financial position of the Board is soundly based, having regard to:

- compliance with statutory financial requirements and achievement of financial targets;
- such financial monitoring and reporting arrangements as may be

specified from time-to-time by Scottish Government Health & Social Care Directorates and/or the Board;

- the impact of planned future policies and known or foreseeable future developments on the financial position;
- Highland's overall performance, strategic policy and planning objective, and ensure mechanisms are in place to promote best value improved efficiency and effectiveness
- ensuring a rigorous and systematic approach to performance monitoring and reporting is in place to enable more strategic and better informed discussions to take place at NHS Highland Board meetings
- review regularly the sections of the NHS Highland Integrated Performance Report relevant to the Committee's responsibility.
- recommend the annual revenue and capital budgets, and financial plans consistent with its statutory financial responsibilities;
- review the Property Strategy (including the acquisition and disposal of property) and capital plans, and make recommendations to the Board.
- the regular review of NHS Highland's Business Continuity Plan and;
- oversight of emergency planning arrangements.
- scrutiny of relevant financial and performance risks on the Corporate Risk register on a bi-monthly basis.
- undertake an annual self-assessment of the Committee's work and effectiveness.

Arrangements for Securing Value for Money

6.2 The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for (a) planning, appraisal, control, accountability and evaluation of the use of resources, and for (b) reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review action (proposed or underway) to ensure that the Board achieves financial balance in line with statutory requirements.

Allocation and Use of Resources

6.3 The Committee has key responsibilities for:

- reviewing the development of the Board's Financial Strategy in support of the Annual Operational Plan, and recommending approval to the Board;
- reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the Board thereon;
- monitoring the use of all resources available to the Board; and
- reviewing all matters relating to Best Value.

6.4 Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment) and the review of the Property Strategy

(including the acquisition and disposal of property), and for making recommendations to the Board as appropriate on any issue within its terms of reference.

6.5 The Committee will receive minutes from the Asset Management Group, Financial Recovery Board and the Performance Recovery Board.

Issues arising from these Committees will be brought to the attention of the Chair of the Finance, Performance and Resources Committee for further consideration as required.

6.6 The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chair of the respective Committee by the end of May each year for presentation to the Audit Committee in June.

6.7 The Annual Report will include the Committee's assessment and conclusions on its effectiveness over the financial year in question.

6.8 The Committee shall draw up and approve, before the start of each financial year, an Annual Work Plan for the Committee's planned work during the forthcoming year.

6.9 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

Performance

6.10 To support the development of a performance management and accountability culture across NHS Highland.

6.11 Receive annual reports and quarterly updates from the Sub-committees established by the Committee in order to provide assurance and accountability.

6.12 To monitor and review risks falling within its remit.

7. AUTHORITY

7.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

7.2 In order to fulfil its remit, the Finance, Performance and Resources Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

8. REPORTING ARRANGEMENTS

8.1 The Finance, Performance and Resources Committee reports directly to NHS Highland Board on its work. The Chair of Committee shall provide assurance on the work of the Committee and the draft minutes will be submitted to the NHS Board meeting for information.

Items requiring urgent attention by the NHS Board can be raised at any time at NHS Board Meetings, subject to the approval of the Chair.

STAFF GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: September 2020

1. PURPOSE

1.5 The purpose of the Staff Governance Committee is to support and maintain a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration. It will ensure that robust arrangements to implement the Staff Governance Standard are in place and monitored

1.6 To assure the Board that the staff governance arrangements across NHS Highland are working effectively.

1.7 As a Committee of the Board, escalate any issues if serious concerns are identified regarding staff governance issues within NHS Highland.

2. COMPOSITION

2.4 The membership of the Staff Governance Committee will be:

- Four Non-Executive members, one of whom will be the Chair of the Committee.
- Employee Director
- Two Highland Partnership Forum (Staffside) Representatives
- Chief Executive

2.5 Ex Officio

Board Chair

2.6 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. Where appropriate, deputies will be permitted. In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Human Resources and Organisational Development
- Deputy Chief Executive

- Nursing Director
- Medical Director
- Director of Public Health
- Chief Officer, Acute
- Chief Officer, Argyll and Bute IJB
- Chief Officer, North Highland
- Head of Occupational Health and Safety
- Deputy Director of HR
- Head of HR, A&B
- Head of Communication and Engagement
- External Culture Advisor
- Staffside Co-Chair of Health & Safety sub committee

2.7 The Director of Human Resources and Organisational Development will act as Lead Officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive members are present. Non- Executive Directors who are unable to attend a meeting should find an substitute to attend in their place.

4. MEETINGS

4.1 The Staff Governance Committee shall meet as necessary to fulfil its purpose but not less than six times a year. Where possible, these meetings should be held to fall between two and four weeks before the NHS Highland Board meeting.

4.2 NHS Highland Board shall appoint a Chair who shall preside at meetings of the Committee and a Vice Chair who will chair in their absence.

4.3 If the Chair is absent from any meeting of the Committee, the Vice Chair shall chair the meeting.

4.4 The agenda and supporting papers will be sent out at least five working days before the meeting.

5. REMIT

5.1 The remit of the Staff Governance Committee is to:

- Consider NHS Highland's performance in relation to its achievements of effective Staff Governance and its compliance with the Staff Governance Standard;

- Give assurance to the Board on the operation of Staff Governance systems within NHS Highland, identifying progress, issues and actions being taken, where appropriate;

- Oversee the commissioning of structures and processes which ensure that the delivery against the standard is being achieved

- Monitor and evaluate strategies and implementation plans relating to people management

- Approve any policy amendment, funding or resource submission to achieve the Staff Governance Standard

- Take responsibility for the timely submission of all staff governance information required for national monitoring arrangements

- Review action taken on recommendations made by the Committee, NHS Boards, or the Scottish Ministers on Staff Governance matters;

- Provide assurance and oversight to the board for the operation of the Highland Partnership Forum, the Health & Safety Sub Committee and the Culture Oversight Group and escalate any matters as required.

- Support the operation of the Highland Partnership Forum and the Local Partnership Forums in their Staff Governance monitoring role and the appropriate flow of information to facilitate this;

- Undertake an annual self-assessment of the Committee's work and effectiveness and share with Scottish Government; and

5.2 The Committee is also required to carry out a review of its function and activities and to provide an Annual Report incorporating a Statement of Assurance. This will be submitted to the Board via the Audit Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit Committee in June.

5.3 The Committee shall draw up and approve, before the start of each financial year, an Annual Work Plan for the Committee's planned work during the forthcoming year.

5.4 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Staff Governance Committee may obtain whatever professional advice it requires, and require Directors or other

officers of the Board to attend meetings.

6.3 Delegated authority is detailed in the Board's Standing Orders, as set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Staff Governance Committee reports directly to NHS Highland Board on its work. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 The Highland Partnership Forum (HPF) will report to the Committee and act as the main implementation body for the Staff Governance agenda.

7.3 The Health and Safety Sub Committee will report to the Committee to ensure that the appropriate processes and resources are in place to facilitate the achievement of Health and Safety Policy Aims and Strategic Objectives and for assurance of and escalation for matters relating to Health & Safety.

7.4 The Culture Oversight Group will report to the Committee on progress with and assurance of the Culture Programme across NHS Highland.

REMUNERATION COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board approval: September 2020

1. PURPOSE AND ROLE

1.1 To consider and agree performance objectives and performance appraisals for staff in the Executive cohort and to oversee performance arrangements for designated senior managers. The Committee will be responsible for applying the remit detailed in NHS: MEL (2000) 25, NHS HDL (2002) 64 and subsequent guidance.

1.2 To direct the appointment process for the Chief Executive and Executive Members of the Board.

2. COMPOSITION

2.1 The membership of the Remuneration Committee will be:

- Board Chair
- Board Vice Chair
- Employee Director

2.2. The Director of Human Resources and Organisational Development shall serve as the Lead Officer to the Committee.

2.3 All Executive members in attendance at the Committee will leave the meeting when any discussion takes place with regard to individual Directors' performance. The NHS Highland Chief Executive will leave the meeting when there is any discussion with regard to their own performance.

3. QUORUM

3.1 Meetings will be quorate when at least two members are present.

4. MEETINGS

4.1 The Committee shall meet as necessary, but not less than three times a year.

4.2 The NHS Highland Board Chair will chair the Committee. If the Chair is absent from the meeting, the Board Vice Chair will chair the meeting.

4.3 The agenda and supporting papers for each meeting will be sent out at least five clear days before the meeting.

4.4 The principal minutes will be circulated to all Committee members. Abridged

minutes edited to remove all personal details will be circulated to all Board members.

5. REMIT

5.1 The remit of the Remuneration Committee is to:

- Agree all the terms and conditions of employment of Executive Directors and Senior Managers of the Board, including:
  - job descriptions
  - job evaluation
  - terms of employment
  - basic pay
  - performance related pay
  - benefits (removal arrangements and cars)
- Agree objectives for executives before the start of the year in which performance is assessed
- Ensure that effective arrangements are in place for carrying out the above two functions in respect of all other senior managers
- Conduct a regular review of the Board's policy for the remuneration and performance assessment of executive directors, other senior managers and medical consultants, in the light of guidance issued by the SGHD and any specific National, External or Internal Audit Report.

The Remuneration Committee, under the leadership of the Chair will:

- Ensure Remuneration Sub-Committee members are fully trained to undertake Committee member duties.
- Ensure efficient and effective use of public monies in relation to managerial and executive pay.
- Ensure that decisions on pay are fully supportable and auditable.
- Ensure that individual targets and assessments of performance against targets are tied to the Board's overall performance in providing health and social care services.
- Take full account of Government policy on pay in the public sector and the need to contain overall management costs when determining pay increases.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Remuneration Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

6.3 Delegated authority is detailed in the Board's Standing Orders and Standing Financial Instructions and is set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Remuneration Committee reports directly to the NHS Highland Board on its work. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

Highland Health and Social Care Committee

Terms of Reference to be included at this point.

NHS Highland

PHARMACY PRACTICES COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board approval: September 2020

1. PURPOSE AND ROLE

The Pharmacy Practices Committee is required to consider applications to provide pharmaceutical services within the Board area and to determine whether the application will be granted.

2. COMPOSITION

2.1 The full membership of the Pharmacy Practices Committee is:

- Chair or Vice Chair (if acting as Chair)
- other lay members (or deputy members)
- pharmacist members (or deputy members) nominated by the Area Pharmaceutical Committee (one of which must be a chemist contractor and one a non contractor chemist)
- Area Medical Committee Nominee (only required in hearing an application relating to an area served by a dispensing GP)

2.2 At the commencement of the meeting there must be an equal number of lay and pharmacist members but the pharmacy members and any nominee of the Area Medical Committee will be required to withdraw immediately before a decision on an application takes place.

2.3 Only the lay members are entitled to remain and to vote.

3. QUORUM

3.1 A pool of possible members of the Pharmacy Practices Committee is available and a minimum membership of 5 (6 in the case of an application relating to an area served by a dispensing GP) is possible for any Committee to remain quorate. (In these circumstances the membership must be Chairman, 2 Lay Members, one Chemist Contractor, one Non Contractor Chemist, - nominees of APC and one Area Medical Committee Nominee (if required).

4. MEETINGS

4.1 There is no specific agenda. The format of each meeting is the same. Each party, starting with the applicant, gives its statement following which all other parties then ask that party questions. This is followed by

members of the Committee asking questions of whichever party has just given its statement. This is repeated until all parties have given their statement and questions have been asked. All parties sum up after this, with the applicant being the last to sum up. The applicant and all the parties then leave the meeting and the Committee considers all the information obtained and presented and considers the application against the 'legal test', as described under "specific responsibilities".

Voting

4.2 Immediately before any decision is made the pharmacist members, and/or employees thereof, and if relevant, the Area Medical Committees nominee, must withdraw and should a vote be necessary, the question shall be determined by a majority of votes of members remaining. The Chair shall not vote in the first instance; they will have a casting vote if the votes cast are equal.

Administrative Arrangements

4.3 The Community Pharmacy Business Manager provides the administrative support for this Committee.

4.4 **Frequency of meetings**

The Committee is convened when required to consider applications received for the provision of pharmaceutical services within NHS Highland Board area. Receipt of these applications is unpredictable**.**

5. REMIT

5.1 Under Regulation 5(10) of the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009, as amended, the Committee will grant the application if it is satisfied that the provision of pharmaceutical services, at the identified premises, is necessary or desirable in order to secure adequate provision of pharmaceutical services in the neighbourhood in which the proposed premises are located unless the PPC considers that the provision of existing services would be prejudiced by the granting of the application to the extent where either primary medical services or pharmaceutical services may no longer be sustainable or secure within a controlled locality, then they must refuse the application.

The factors which need to be considered include:

a) What is the neighbourhood in which the premises are located?
b) What are the existing services in the neighbourhood?
c) Are these services adequate or not?
d) Is it necessary to grant the application in order to secure adequate provision of pharmaceutical services in the neighbourhood?
e) Is it desirable to grant the application in order to secure adequate provision of pharmaceutical services in the neighbourhood?

In order to consider these questions the following information will include, where necessary:

- The location of the premises, the geography of the area and the

social factors which may create boundaries.

- What services already are provided by other contractors in the area, for example, other pharmacies, GP and dental practices?
- What are the transport patterns and how do people travel?
- The number of people who require services?
- What services are provided during what hours?

The manner in which the application is considered shall be a matter for the Committee to determine. However, in most circumstances an oral hearing will be held to ensure that all members understand the evidence and that points of clarification can be obtained from the applicant or other parties. Wherever possible, the Committee will convene its meetings in the area local to the proposed premises and will undertake a site visit to obtain, first hand, knowledge of the local area and of the proposed premises.

6. AUTHORITY

6.1 The Committee considers applications for the provision of general pharmaceutical services within NHS Highland Board area. In considering these applications, the Committee is acting on behalf of the NHS Board.

7. REPORTING ARRANGEMENTS

7.1 The Pharmacy Practices Committee reports directly to NHS Highland Board on its work. The Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

[TEMPLATE FOR COMMITTEE STATEMENT OF ASSURANCE
TO THE AUDIT COMMITTEE]

ANNUAL STATEMENT OF ASSURANCE OF NHS HIGHLAND [*COMMITTEE TITLE*]
FOR [*YEAR*]

NHS Highland
[Name of Committee]Annual Report

Note: A maximum of approximately 4 sides of A4 should be aimed for. There should be no appendices unless fundamental to the work of the Committee.

To: NHS Highland Audit Committee

From: [Name] Chair, [Name of Committee]

Subject: [Name of Committee] Committee Report – [Period Covered- Financial Year]

1 Background

In line with sound governance principles, an Annual Report is submitted from the **[Name of Committee]** to the Audit Committee. This is undertaken to cover the complete financial year, and allows the Audit Committee to provide the Board of NHS Highland with the assurance it needs to approve the Governance Statement, which forms part of the Annual Accounts.

2 Activity [Dates covered]

[A summary of the key activities during the year and particular areas of scrutiny/progress you would like to highlight and if available a copy of the annual work plan for the committee. The number of meetings during the year, that the Minutes have been submitted to the Board along with reports relating to key items and a list of members and their attendance at meetings etc) **NB This should not be a list of agenda items from every meeting.**]

3 Sub Groups

[Key issues from any sub groups during the year. This should not be a description of what other groups have done. This should be restricted to any significant issues arising from the Groups reporting into the Committee and action taken as a result.]

4 External Reviews

[Summary of results of any significant external reviews (e.g. QIS/Staff Surveys/Audit Scotland etc) during the year]

5 Any relevant Key Performance Indicators

[Summary of results against any relevant KPIs during the year]

6 Emerging issues and key issues to address/improve the following year

[Summary of any issues which the committee intends to focus on during the coming year]

7 Conclusion

This should include a specific declaration that the systems of control within the respective areas within the remit of the committee are considered to be operating adequately and effectively. (NB If this is not the case, this should be reported immediately to the Chief Executive as soon as the Chair becomes aware of this)

[Name]
Chair
[Name of Committee]
[Date]

NB Reports to be submitted to the May meeting of the Audit Committee each year.

SECTION B

CODE of CONDUCT

for

MEMBERS OF NHS HIGHLAND BOARD

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SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

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

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

1.3 The Act requires the Scottish Ministers to lay before Parliament a Code of Conduct for Councillors and a Model Code for Members of Devolved Public Bodies. The Model Code for members was first introduced in 2002 and has now been revised in December 2013 following consultation and the approval of the Scottish Parliament. These revisions will make it consistent with the relevant parts of the Code of Conduct for Councillors, which was revised in 2010 following the approval of the Scottish Parliament.

1.4 As a member of NHS HIGHLAND, "the Board", it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct which has now been made by the Board.

Appointments to the Boards of Public Bodies

1.5 Public bodies in Scotland are required to deliver effective services to meet theneeds of an increasingly diverse population. In addition, the Scottish Government's equality outcome on public appointments is to ensure that Ministerial appointments are more diverse than at present**.** In order to meet both of these aims, a board should ideally be drawn from varied backgrounds with a wide spectrum of characteristics, knowledge and experience. It is crucial to the success of public bodies that they attract the best people for the job and therefore it is essential that a board's appointments process should encourage as many suitable people to apply for positions and be free from unnecessary barriers. You should therefore be aware of the varied roles and functions of the public body on which you serve and of wider diversity and equality issues. You should also take steps to familiarise yourself with the appointment process that your board will have agreed with the Scottish Government's Public Appointment Centre of Expertise.

1.6 You should also familiarise yourself with how NHS Highland's policy operates in relation to succession planning, which should ensure public bodies have a strategy to make sure they have the staff in place with the skills, knowledge and experience necessary to fulfil their role economically, efficiently and effectively.

Guidance on the Code of Conduct

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

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

1.9 You should familiarise yourself with the Scottish Government publication "OnBoard a guide for board members of public bodies in Scotland". This publication will provide you with information to help you in your role as a member of a public body in Scotland and can be viewed on the Scottish Government website.

Enforcement

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

SECTION 2: KEY PRINCIPLES OF THE CODE OF CONDUCT

2.1 The general principles upon which this Code is based should be used for guidance and interpretation only. These general principles are:

Duty
You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. You have a duty to act in the interests of the public body of which you are a member and in accordance with the core functions and duties of that body.

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

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

Objectivity
You must make decisions solely on merit and in a way that is consistent with the functions of NHS Highland when carrying out public business including making

appointments, awarding contracts or recommending individuals for rewards and benefits.

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

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

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

Leadership
You have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of NHS Highland and its members in conducting public business.

Respect
You must respect fellow members of Highland NHS Board and employees of NHS Highland and the role they play, treating them with courtesy at all times. Similarly you must respect members of the public when performing duties as a member of Highland NHS Board.

2.2 You should apply the principles of this Code to your dealings with fellow members of NHS Highland, its employees and other stakeholders. Similarly you should also observe the principles of this Code in dealings with the public when performing duties as a member of Highland NHS Board.

SECTION 3: GENERAL CONDUCT

3.1 The rules of good conduct in this section must be observed in all situations where you act as a member of Highland NHS Board.

Conduct at Meetings

3.2 You must respect the chair, your colleagues and employees of NHS Highland in meetings. You must comply with rulings from the chair in the conduct of the business of these meetings.

Relationship with Board Members and Employees of NHS Highland (including those employed by contractors providing services)

3.3 You will treat your fellow board members and any staff employed by NHS Highland with courtesy and respect. It is expected that fellow board members and employees will show you the same consideration in return. It is good practice for employers to provide examples of what is unacceptable

behaviour in their organisation.

Public bodies should promote a safe, healthy and fair working environment for all. As a board member you should be familiar with the policies of NHS Highland in relation to bullying and harassment in the workplace and also lead by exemplar behaviour.

Remuneration, Allowances and Expenses

3.4 You must comply with any rules of NHS Highland regarding remuneration,allowances and expenses.

Gifts and Hospitality

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

3.6 You must never ask for gifts or hospitality.

3.7 You are personally responsible for all decisions connected with the offer oracceptance of gifts or hospitality offered to you and for avoiding the risk of damage to public confidence in NHS Highland. As a general guide, it is usually appropriate to refuse offers except:

(a) isolated gifts of a trivial character, the value of which must not exceed £50;

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

(c) gifts received on behalf of NHS Highland.

3.8 You must not accept any offer of a gift or hospitality from any individual ororganisation which stands to gain or benefit from a decision NHS Highland may be involved in determining, or who is seeking to do business with your organisation, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit in your capacity as a member of Highland NHS Board then, as a general rule, you should ensure that NHS Highland pays for the cost of the visit.

3.9 You must not accept repeated hospitality or repeated gifts from the same source.

3.10 Members of devolved public bodies should familiarise themselves with the terms of the Bribery Act 2010 which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality Requirements

3.11 There may be times when you will be required to treat discussions, documents or other information relating to the work of NHS Highland in a confidential manner.

You will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. You must always respect the confidential nature of such information and comply with the requirement to keep such information private.

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

Use of NHS Highland Facilities

3.13 Members of public bodies must not misuse facilities, equipment, stationery, telephony, computer, information technology equipment and services, or use them for party political or campaigning activities. Use of such equipment and services etc. must be in accordance with NHS Highland's policy and rules on their usage. Care must also be exercised when using social media networks not to compromise your position as a member of Highland NHS Board.

Appointment to Partner Organisations

3.14 You may be appointed, or nominated by NHS Highland, as a member of another body or organisation. If so, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body.

3.15 Members who become directors of companies as nominees of their public body will assume personal responsibilities under the Companies Acts. It is possible that conflicts of interest can arise for such members between the company and NHS Highland. It is your responsibility to take advice on your responsibilities to NHS Highland and to the company. This will include questions of declarations of interest.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out the kinds of interests, financial and otherwise which you have to register. These are called "Registerable Interests". You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in NHS Highland's Register. It is your duty to ensure any changes in circumstances are reported within one month of them changing.

4.2 [1]The Regulations[1] as amended describe the detail and timescale for registering interests. It is your personal responsibility to comply with these regulations and you should review regularly and at least once a year your personal circumstances.

Annex B contains key definitions and explanatory notes to help you decide what is required when registering your interests under any particular category.

The interests which require to be registered are those set out in the following paragraphs and relate to you. It is not necessary to register the interests of your spouse or cohabitee.

Category One: Remuneration

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

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

4.4 In relation to 4.3 above, the amount of remuneration does not require to be registered and remuneration received as a member does not have to be registered.

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

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

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

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

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

[1] SSI - The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003 Number 135, as amended.

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

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

Category Two: Related Undertakings

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

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

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

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

Category Three: Contracts

4.15 You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in paragraph 4.19 below) have made a contract with NHS Highland:

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

(ii) which has not been fully discharged.

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

Category Four: Houses, Land and Buildings

4.17 You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of NHS Highland.

4.18 The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to the NHS Highland and to the public, or could influence your actions, speeches or decision making.

Category Five: Interest in Shares and Securities

4.19 You have a registerable interest where you have an interest in shares comprised in the share capital of a company or other body which may be significant to, of relevance to, or bear upon, the work and operation of (a) NHS Highland and (b) the nominal value of the shares is:

(i) greater than 1% of the issued share capital of the company or other body; or
(ii) greater than £25,000.

Where you are required to register the interest, you should provide the registered name of the company in which you hold shares; the amount or value of the shares does not have to be registered.

Category Six: Gifts and Hospitality

4.20 You must register the details of any gifts or hospitality received within your current term of office. This record will be available for public inspection. It is not however necessary to record any gifts or hospitality as described in paragraph 3.7 (a) to (c) of this Code.

Category Seven: Non–Financial Interests

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

4.22 In the context of non-financial interests, the test to be applied when considering appropriateness of registration is to ask whether a member of the public might reasonably think that any non-financial interest could potentially affect your responsibilities to NHS Highland and to the public, or could influence your actions, speeches or decision-making.

SECTION 5: DECLARATION OF INTERESTS

General

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

5.2 Public bodies inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in NHS Highland and its members depends on it being clearly understood that decisions are taken in the

public interest and not for any other reason.

5.3 In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must, however, always comply with the **objective test** ("the objective test") which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your discussion or decision making in your role as a member of a public body.

5.4 If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration and you are advised to err on the side of caution. If a board member is unsure as to whether a conflict of interest exits, they should seek advice from the board chair.

5.5 As a member of a public body you might serve on other bodies. In relation to service on the boards and management committees of limited liability companies, public bodies, societies and other organisations, you must decide, in the particular circumstances surrounding any matter, whether to declare an interest. Only if you believe that, in the particular circumstances, the nature of the interest is so remote or without significance, should it not be declared. You must always remember the public interest points towards transparency and, in particular, a possible divergence of interest between your public body and another body. Keep particularly in mind the advice in paragraph 3.15 of this Code about your legal responsibilities to any limited company of which you are a director.

Interests which Require Declaration

5.6 Interests which require to be declared if known to you may be financial or non-financial. They may or may not cover interests which are registerable under the terms of this Code. Most of the interests to be declared will be your personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration. The paragraphs which follow deal with (a) your financial interests (b) your non-financial interests and (c) the interests, financial and non-financial, of other persons.

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

Your Financial Interests

5.8 You must declare, if it is known to you, any financial interest (including any financial interest which is registerable under any of the categories prescribed in Section 4 of this Code). If, under category one (or category seven in respect of non-financial interests) of section 4 of this Code, you have registered an interest

(a) as an employee of the Board; or
(b) as a Councillor or a Member of another Devolved Public Body where the Council or other Devolved Public Body, as the case may be, has nominated or appointed you as a Member of the Board; you do not, for that reason alone, have to declare that interest.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

Your Non-Financial Interests

5.9 You must declare, if it is known to you, any non-financial interest if:

(i) that interest has been registered under category seven (Non-Financial Interests) of Section 4 of the Code; or

(ii) that interest would fall within the terms of the objective test.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

The Financial Interests of Other Persons

5.10 The Code requires only your financial interests to be registered. You also, however, have to consider whether you should declare any financial interest of certain other persons.

You must declare if it is known to you any financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;

(vi) a person from whom you have received registerable expenses.

There is no need to declare an interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of and voting on the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

5.11 This Code does not attempt the task of defining “relative” or “friend” or “associate”. Not only is such a task fraught with difficulty but is also unlikely that such definitions would reflect the intention of this part of the Code. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of Highland NHS Board and, as such, would be covered by the objective test.

The Non-Financial Interests of Other Persons

5.12 You must declare if it is known to you any non-financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable election expenses.

There is no need to declare the interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

There is only a need to withdraw from the meeting if the interest is clear and substantial.

Making a Declaration

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

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

Frequent Declarations of Interest

5.15 Public confidence in a public body is damaged by perception that decisions taken by that body are substantially influenced by factors other than the public interest. If you would have to declare interests frequently at meetings in respect of your role as a board member you should not accept a role or appointment with that attendant consequence. If members are frequently declaring interests at meetings then they should consider whether they can carry out their role effectively and discuss with their chair. Similarly, if any appointment or nomination to another body would give rise to objective concern because of your existing personal involvement or affiliations, you should not accept the appointment or nomination.

Dispensations

5.16 In some very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and non-financial interests which would otherwise prohibit you from taking part and voting on matters coming before your public body and its committees.

5.17 Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

SECTION 6: LOBBYING AND ACCESS TO MEMBERS OF PUBLIC BODIES

Introduction

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

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

Rules and Guidance

6.3 You must not, in relation to contact with any person or organisation that lobbies do anything which contravenes this Code or any other relevant rule of NHS Highland or any statutory provision.

6.4 You must not, in relation to contact with any person or organisation who lobbies, act

in any way which could bring discredit upon NHS Highland.

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

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

6.7 You should not accept any paid work:-

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

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

6.8 If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of NHS Highland.

ANNEX A

SANCTIONS AVAILABLE TO THE STANDARDS COMMISSION FOR BREACH OF THE CODE

(a) Censure – the Commission may reprimand the member but otherwise take no action against them;

(b) Suspension – of the member for a maximum period of one year from attending one or more, but not all, of the following:

i) all meetings of the public body;

ii) all meetings of one or more committees or sub-committees of the public body;

(iii) all meetings of any other public body on which that member is a representative or nominee of the public body of which they are a member.

(c) Suspension – for a period not exceeding one year, of the member's entitlement to attend all of the meetings referred to in (b) above;

(d) Disqualification – removing the member from membership of that public body for a period of no more than five years.

Where a member has been suspended, the Standards Commission may direct that any remuneration or allowance received from membership of that public body be reduced, or not paid.

Where the Standards Commission disqualifies a member of a public body, it may go on to impose the following further sanctions:

(a) Where the member of a public body is also a councillor, the Standards Commission may disqualify that member (for a period of no more than five years) from being nominated for election as, or from being elected, a councillor. Disqualification of a councillor has the effect of disqualifying that member from their public body and terminating membership of any committee, sub-committee, joint committee, joint board or any other body on which that member sits as a representative of their local authority.

(b) Direct that the member be removed from membership, and disqualified in respect of membership, of any other devolved public body (provided the members' code applicable to that body is then in force) and may disqualify that person from office as the Water Industry Commissioner.

In some cases the Standards Commission do not have the legislative powers to deal with sanctions, for example if the respondent is an executive member of the board or appointed by the Queen. Sections 23 and 24 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 refer.

Full details of the sanctions are set out in Section 19 of the Act.

ANNEX B

DEFINITIONS

"Chair" includes Board Convener or any person discharging similar functions under alternative decision making structures.

"Code" code of conduct for members of devolved public bodies

"Cohabitee" includes a person, whether of the opposite sex or not, who is living with you in a relationship similar to that of husband and wife.

"Group of companies" has the same meaning as "group" in section 262(1) of the Companies Act 1985. A "group", within s262 (1) of the Companies Act 1985, means a parent undertaking and its subsidiary undertakings.

"Parent Undertaking" is an undertaking in relation to another undertaking, a subsidiary undertaking, if a) it holds a majority of the rights in the undertaking; or b) it is a member of the undertaking and has the right to appoint or remove a majority of its board of directors; or c) it has the right to exercise a dominant influence over the undertaking (i) by virtue of provisions contained in the undertaking's memorandum or articles or (ii) by virtue of a control contract; or d) it is a councillor of the undertaking and controls alone, pursuant to an agreement with other shareholders or councillors, a majority of the rights in the undertaking**.**

"A person" means a single individual or legal person and includes a group of companies.

"Any person" includes individuals, incorporated and unincorporated bodies, trade unions, charities and voluntary organisations.

"**Public body"** means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

"Related Undertaking" is a parent or subsidiary company of a principal undertaking of which you are also a director. You will receive remuneration for the principal undertaking though you will not receive remuneration as director of the related undertaking.

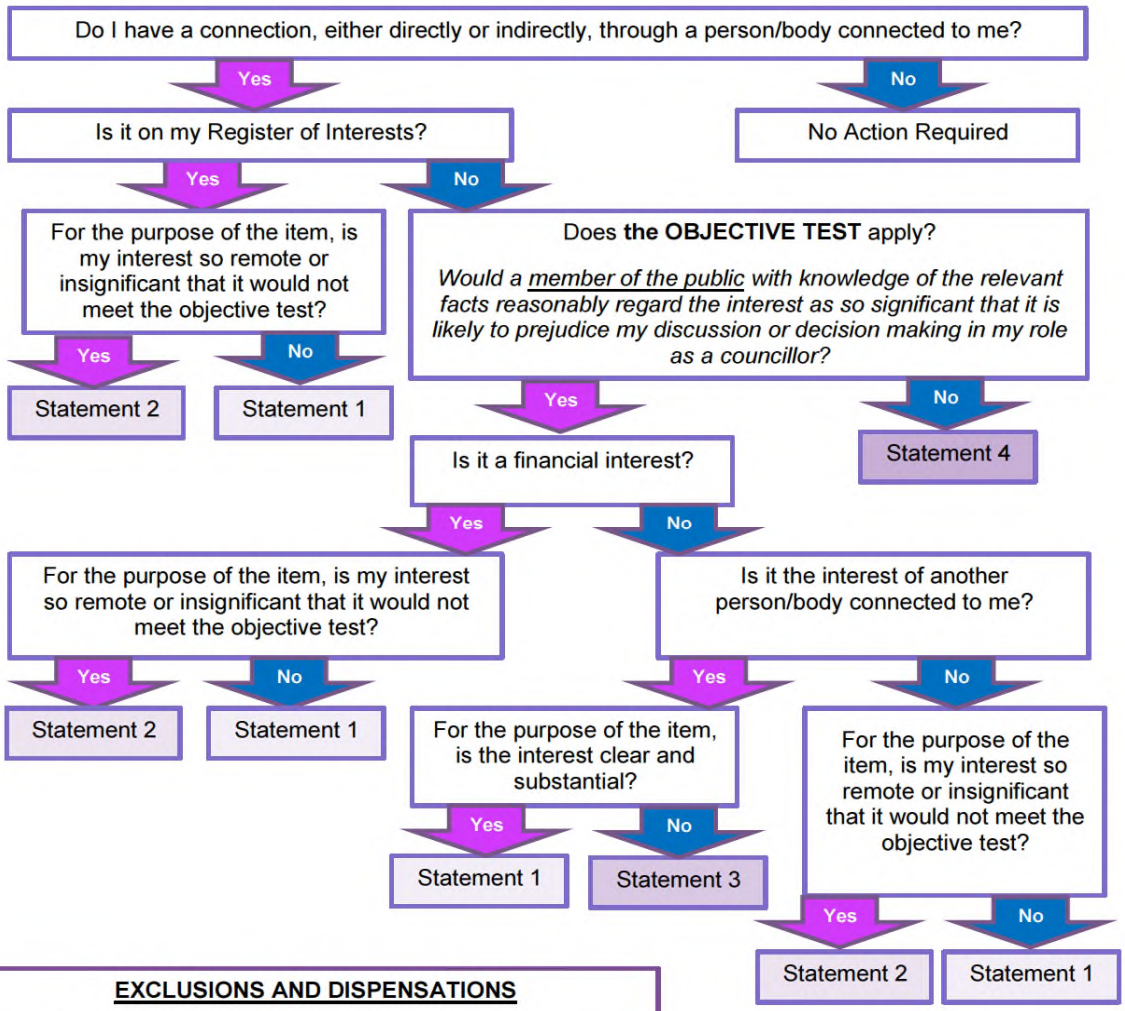
"Remuneration" includes any salary, wage, share of profits, fee, expenses, other monetary benefit or benefit in kind. This would include, for example, the provision of a company car or travelling expenses by an employer.

"Spouse" does not include a former spouse or a spouse who is living separately and apart from you.

"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

ANNEX C

STANDARDS COMMISION FLOW CHART ON DECLARATIONS OF INTEREST



STATEMENTS	
Statement 1:	I have an interest in item XX by virtue of (explain the nature of connection) and so I will leave the meeting and take no part in the discussions and / or voting on the item.
*Statement 2:	I have an interest/registered interest in item XX by virtue of (explain the nature of connection) but have applied the objective test and concluded that it is so remote or insignificant that I will remain and participate.
*Statement 3:	I have an interest in item XX by virtue of (explain the nature of connection) but have applied the objective test and concluded that it is not clear and substantial. Therefore, I will remain and participate.
Statement 4:	I have a connection to item XX by virtue of (explain the nature of connection). However, having applied the objective test, I have concluded that I have no interest to declare.

***Does not apply for decisions on planning applications, planning agreements, enforcement action or the Local Review Body.**

GENERAL EXCLUSIONS - Where a general exclusion applies, you do not require to declare the interest and can remain and take part.

The general exclusions are as follows:-

- As a council tax payer or rate payer in relation to the Council's public services;
- In relation to setting the Council tax;
- Matters affecting councillors' remuneration, allowances, expenses, support services and pension; or
- As a council house tenant.

SPECIFIC EXCLUSIONS - Where a specific exclusion applies, you will require to declare the interest but you can remain and take part.*
*Specific exclusions do not apply to quasi-judicial or regulatory matters, e.g. planning or licensing applications. In such cases you will require to declare the interest and withdraw.

The specific exclusions cover the following interests:-

- **As a member, or director of, an outside body, where you have been appointed or nominated by the Council or had your appointment approved by the Council and the appointment is on your register of interests.** Outside bodies include:-
  - a devolved public body e.g. Visit Scotland, Children's Reporter, NHS Lothian;
  - a public body established by enactment or in pursuance of statutory powers or by the authority of statute or a statutory scheme, e.g. SESTRANS;
  - a body discharging functions of Scottish Enterprise or Highlands and Islands Enterprise by agreement from either agency;
  - a company established wholly or mainly to provided services to the Council which has contracted with the Council to supply said services.
- As a member of the Cairngorm National Park Authority. Please note there are special rules in relation to the CNPA in that Members will be able to remain and participate in respect of certain planning applications. Please take advice from your Council's Monitoring Officer in such circumstances.

Where a specific exclusion applies the following wording can be used:-
I have an interest in item XX by virtue of *[insert details of interest]*. However, a specific exclusion applies and, therefore, I will remain and participate.

DISPENSATIONS

In some very limited circumstances the Standards Commission can grant dispensations in relation to the existence of financial or non-financial interests which, in terms of the Councillors' Code of Conduct, would otherwise prohibit participation in discussion and voting.

For example a dispensation was granted to councillors who are appointed by their Councils to Health and Social Care Integration Joint Boards. This allows them to participate in health and social care matters without having to declare an interest at Council meetings.

If a dispensation is in place, the following wording can be used:-
I have an interest in item XX by virtue of my membership of XX, however, a dispensation has been granted therefore I will remain and participate.

SECTION C

NHS Highland
Standing Financial Instructions

STANDING FINANCIAL INSTRUCTIONS

INDEX

1. INTRODUCTION

1.1 Standing Financial Instructions (SFIs) are issued in accordance with the financial directions made under the provisions of the NHS (Financial Provisions) (Scotland) Regulations 1974, and all other enabling powers, for the regulation of the conduct of the Board, its members, officers and agents in relation to all financial matters. These SFIs form part of the Standing Orders and should be used along with the Standing Orders and Scheme of Delegation.

1.2 **Terminology**

Any expression to which a meaning is given in the Health Service Acts, Scottish Statutory Instrument number 302 (2001) which brought NHS Boards into being, or in the financial regulations made under the Acts shall have the same meaning in these Instructions; and:

(a) "NHS Highland" means all elements of the NHS under the auspices of Highland Health Board.

(b) "Board" and "Health Board" mean Highland NHS Board, the common name of Highland Health Board.

(c) "Budget" means a resource expressed in financial terms and set by the Board for the purposes of carrying out for a specified period any or all functions of the Health Board.

(d) "Chief Executive" means the Chief Officer of the Health Board.

(e) "Director of Finance" means the Chief Financial Officer of the Health Board.

(f) "Budget Holder" means any individual with delegated authority to manage finances (income and/or expenditure) for a specific area of the Board.

1.3 All staff individually and collectively are responsible for the security of the property of the Board, for avoiding loss, for economy and efficiency in the use of the resources and for conforming with the requirements of the Code of Corporate Governance, including Standing Orders, Standing Financial Instructions and Financial Operating Procedures.

1.4 The Director of Finance, on behalf of the Chief Executive, shall be responsible for supervising the implementation of the Board's Standing Financial Instructions and Financial Operating Procedures and for co-ordinating any action necessary to further these as agreed by the Chief Executive. The Director of Finance shall review these at least every two years and be accountable to the Board for these duties.

1.5 Wherever the title, Chief Executive, Director of Finance, or other nominated officer is used in these Instructions, it shall be deemed to include such other staff who have been duly authorised to represent them.

1.6 All relevant employees and agents shall be provided with a copy of these SFIs and are required to complete a form stating that these Instructions have been read and understood and that the individual will comply with the Instructions. They must also sign for any amendments.

1.7 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting.

1.8 Failure to comply with Standing Financial Instructions is a disciplinary matter, which could result in dismissal.

1.9 The Standing Financial Instructions along with the Scheme of Delegation and Financial Operating Procedures provide details of delegated financial responsibility and authority.

2. KEY RESPONSIBILITIES FOR FINANCIAL GOVERNANCE

The Board and Audit Committee

2.1 The Board shall approve these SFIs and Scheme of Delegation

2.2 The Board shall ensure and be assured that the SFIs and Scheme of Delegation are complied with at all times.

2.3 The Board shall agree the terms of reference of the Audit Committee which must conform with current relevant Scottish Government Instruction and other guidance on good practice.

2.4 The Board shall perform its functions within the total funds allocated by the Scottish Government.

The Chief Executive (Accountable officer)

2.5 The Chief Executive as Accountable Officer for the organisation is ultimately responsible for ensuring that the Board meets its obligations to perform its functions within the allocated financial resources. The Director of Finance is responsible for providing a sound financial framework that assists the Chief Executive when fulfilling these commitments.

2.6 The Board shall delegate executive responsibility for the performance of its functions to the Chief Executive. Board Members shall exercise financial supervision and control by requiring the submission and approval of budgets within approved allocations, by defining and approving essential features of the arrangements in respect of important procedures and financial systems, including the need to obtain value for money, and by defining specific responsibilities placed on individuals.

2.7 It shall be the duty of the Chief Executive to ensure that existing staff and all new employees and agents are notified of their responsibilities within these Instructions.

The Director of Finance

2.8 Without prejudice to any other functions of employees of the Board, the duties of the Director of Finance shall include the provision of financial advice to the Board and its employees, the design, implementation and supervision of systems of financial control and preparation and maintenance of such accounts, certificates, estimates, records and reports as the Board may require for the purpose of carrying out its statutory duties.

2.9 The Director of Finance shall keep records of the Board's transactions sufficient to disclose with reasonable accuracy at any time the financial position of the Board.

2.10 The Director of Finance shall require any individual who carries out a financial function to discharge their duties in a manner, and keep any records in a form, that shall be to the satisfaction of the Director of Finance.

2.11 The Director of Finance shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal checks to supplement these Standing Financial Instructions.

2.12 The Director of Finance shall be responsible for setting the Board's accounting policies, consistent with the Scottish Government and Treasury guidance and generally accepted accounting practice.

2.13 The Director of Finance will either undertake the role of Fraud Liaison Officer or nominate another senior manager to the role, to work with Counter Fraud Services and co-ordinate the reporting of Fraud and Thefts.

2.14 The Director of Finance is entitled without necessarily giving prior notice to require and receive:-

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises or employee of the health board;
- the production of any cash, stores or other property of the health board under an employee's control; and
- explanations concerning any matter under investigation.

All Directors and Employees

2.15 All directors and employees, individually and working together, are responsible for:

Keeping the property of the Board secure, and to apply appropriate routine security practices as may be determined by the Board. This includes:-

a. ensuring that the assets within their area of responsibility are included within the appropriate asset register (see Section 7);
b. ensuring that asset records/registers are kept up-to-date;
c. performing verification exercises to confirm the existence and condition of the assets, and the completeness of the appropriate asset register; and
d. following any prescribed procedures to notify the organisation of any theft, loss or damage to assets.
    - Avoiding loss;
    - Securing Best Value in the use of resources; and
    - Following these SFIs and any other policy or procedure that the Board may approve.

2.16 All budget holders shall ensure that:-

- Information is provided to the Director of Finance to enable budgets to be compiled;
- Budgets are only used for their stated purpose; and
- Budgets are never exceeded.

2.17 When a budget holder expects their expenditure will exceed their delegated budget, they must secure an increased budget, or seek explicit approval to overspend before doing so.

2.18 All NHS staff who commit NHS resources directly or indirectly must be impartial and honest in their conduct of business and all employees must remain beyond suspicion.

2.19 All employees shall observe the requirements of MEL (1994) 48, which sets out the Code of Conduct for all NHS staff. There are 3 crucial public service values which underpin the work of the health service:-

Conduct
There should be an absolute standard of honesty and integrity which should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers; in the use of information acquired in the course of NHS duties; in dealing with the assets of the NHS.

Accountability
Everything done by those who work in the NHS must be able to stand the test of parliamentary and public scrutiny, judgements on propriety and professional codes of conduct.

Openness
The Board should be open about its activities and plans so as to promote confidence between the component parts of NHS Highland, other health organisations and its staff, patients and the public.

2.20 All employees shall:-

- Ensure that the interest of patients remain paramount at all times;
- Be impartial and honest in the conduct of their official business;
- Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money; and
- Demonstrate appropriate ethical standards of personal conduct.

2.21 Furthermore all employees shall not:-

- Abuse their official position for the personal gain or to the benefit of their family or friends;
- Undertake outside employment that could compromise their NHS duties; and
- Seek to advantage or further their private business or interest in the course of their official duties.

2.22 The Director of Finance shall publish supplementary guidance and procedures in the form of Financial Operating Procedures to ensure that the above principles are understood and applied in practice.

2.23 The Chief Executive shall establish procedures for voicing complaints or concerns about misadministration, breaches of the standards of conduct, suspicions of criminal behaviour (e.g. theft, fraud, bribery) and other concerns of an ethical nature.

2.24 All employees must protect themselves and the Board from any allegations of impropriety by seeking advice from their line manager, or from the appropriate contact point, whenever there is any doubt as to the interpretation of these standards.

3. AUDIT

Audit Committee

3.1 In accordance with Standing Orders the Board shall formally establish an Audit Committee, with clearly defined terms of reference.

3.2 Where the Audit committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chairperson of the Audit Committee should raise the matter at a full meeting of the Board. In considering whether to do so, the Committee must be mindful of the arrangements with NHS Counter Fraud Services (CFS) and the role of the Fraud Liaison Officer (FLO). Exceptionally, the matter may need to be referred to the Scottish Government Health & Social Care Directorates (SGHSCD).

3.3 It is the responsibility of the Audit Committee to ensure an effective internal audit service is provided and this will be largely influenced by the professional judgement of the Director of Finance.

Director of Finance

3.4 The Director of Finance is responsible for:

a. Ensuring there are arrangements to measure, evaluate and report on the effectiveness of internal control and efficient use of resources, including the establishment of a professional internal audit function headed by a Chief Internal Auditor;

b. Ensuring that Internal Audit is adequate and meets the mandatory NHS internal audit standards;

c. Taking appropriate steps, in line with SGHSCD guidance, to involve CFS and/or the Police in cases of actual or suspected fraud, misappropriation, and other irregularities;

d. Ensuring that the Chief Internal Auditor prepares the following risk based plans for approval by the Audit Committee:

- Strategic audit plan covering the coming four years,
- A detailed annual plan for the coming year.

e. Ensuring that an annual internal audit report is prepared by the Chief Internal Auditor, in accordance with the timetable laid down by the Audit Committee, for the consideration of the Audit Committee and the Board.

The report should include:

- A clear statement on the adequacy and effectiveness of internal control;
- Main internal control issues and audit findings during the year;
- Extent of audit cover achieved against the plan for the year.

f. Progress on the implementation of internal audit recommendations including submission to the Audit Committee.

3.5 The Director of Finance shall refer audit reports to the appropriate officers designated by the Chief Executive and failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive.

Internal Audit

3.6 Internal Audit shall adopt the Public Sector Internal Audit Standards (PSIAS), which

are mandatory and which define internal audit as "an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes."

Minor deviations from the PSIAS should be reported to the Audit Committee. More significant deviations should be considered for inclusion in the Annual Governance Statement.

3.7 Internal Audit activity must evaluate and contribute to the improvement of governance, risk management and control processes using a systematic and disciplined approach. Internal Audit activity and scope is fully defined within the Audit plan, approved by the Audit Committee.

3.8 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance, or the nominated FLO, must be notified immediately, and before any detailed investigation is undertaken.

3.9 The Chief Internal Auditor is 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 (in which case they shall have a duty to safeguard that confidentiality), within the confines of the data protection act.

(b) Access at all reasonable times to any land, premises or employees of the Board;

(c) The production or identification by any employee of any cash, stores or other property of the Board under an employee's control; and

(d) Explanations concerning any matter under investigation.

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

3.11 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting and follow-up systems for internal audit shall be agreed between the Director of Finance, the Audit Committee and Chief Internal Auditor. The agreement shall comply with the guidance on reporting contained in Government Internal Audit Standards.

External Audit

3.12 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 which supersedes the Local Government (Scotland) Act 1973 (Part VII) as amended by the National Health Services and Community Care Act 1990.

3.13 The appointed auditor has a general duty to satisfy themselves that:

(a) The Board's accounts have been properly prepared in accordance with the Direction of the Scottish Ministers to comply with the accounting principles and disclosure requirements of the edition of the Government Financial Reporting Manual (FReM) which is in force for the year for which the statement of accounts are prepared;

(b) Proper accounting practices have been observed in the preparation of the accounts;

(c) The Board has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources.

3.14 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 fairly the financial position of the Board;

(b) The Board's main financial systems;

(c) The arrangements in place at the Board for the 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.

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

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

4. FINANCIAL MANAGEMENT

This section applies to both revenue and capital budgets.

Planning

4.1 The Scottish Government has set the following financial targets for all boards:-

- To operate within the revenue resource limit, see 4.2.
- To operate within the capital resource limit.
- To operate within the cash requirement.

4.2 All Boards are required to develop a balanced plan over a three year period. This requires Boards to deliver a break even position over a three year period. In each year, Boards have flexibility to underspend or overspend up to one per cent of their annual resource budgets.

All Boards will be required to develop a balanced plan over a three-year period in order to benefit from the increased flexibility. Where this is not delivered, the NHS Board Performance Escalation Framework will be put in place.

The Chief Executive shall produce an Annual Operational Plan. The Chief Executive

shall submit a Plan for approval by the Board that takes into account financial targets and forecast limits of available resources. The Annual Operational Plan shall contain:-

- a statement of the significant assumptions within the Plan; and
- details of major changes in workload, delivery of services or resources required to achieve the plan.

4.3 Before the financial year begins, the Director of Finance shall prepare and present a financial plan to the Board. The report shall:-

- show the total allocations received from the Scottish Government and their proposed uses, including any sums to be held in reserve;
- be consistent with the Annual Operational Plan;
- be consistent with the Board's financial targets;
- identify potential risks;
- identify funding and expenditure that is of a recurring nature; and
- identify funding and expenditure that is of a non-recurring nature.

4.4 The Health Board shall approve the financial plan for the forthcoming financial year.

4.5 The Director of Finance shall continuously review the financial plan, to ensure that it meets the Board's requirements and the delivery of financial targets.

4.6 The Director of Finance shall regularly update the Board on significant changes to the allocations and their uses.

4.7 The Director of Finance shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

4.8 The Director of Finance shall establish the systems for identifying and approving how the Board's capital allocation will be used, consisting of proposals for individual schemes, major equipment, IT developments, backlog maintenance, statutory compliance works and minor scheme provision. The approval of business cases shall be as described in the Scheme of Delegation.

4.9 The Director of Finance shall release capital funds allowing for project start dates and phasing.

Budgetary Control

4.10 The Board shall approve the opening budgets for each financial year on an annual basis.

4.11 The Chief Executive shall delegate the responsibility for budgetary control to designated budget holders. The Scheme of Delegation sets out the delegated authorities to take decisions and approve expenditure for certain posts.

4.12 Employees shall only act on their delegated authority when there is an approved budget in place to fund the decisions they make.

4.13 Delegation of budgetary responsibility shall be in writing and be accompanied by a

clear definition of:-

- the amount of the budget;
- the purpose(s) of each budget heading;
- what is expected to be delivered with the budget in terms of organisational performance; and
- how the budget holder will report and account for their budgetary performance.

4.14 The Chief Executive/Director of Finance may agree a virement (administrative transfer of funds) procedure for non-pay expenditure that would allow budget holders to transfer resources from one budget heading to another

4.15 The Director of Finance shall devise and maintain systems of budgetary control. These will include:-

- monthly financial reports to the Board in a form approved by the Board containing:-
  a. net expenditure of the Board for the financial year to date; and
  b. a forecast of the Board's expected net expenditure for the remainder of the year on a monthly basis from the month 2 position onwards.
  c. capital project spend and projected outturn against plan;
  d. explanations of any material variances from plan and/or emerging trends;
  e. details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
- the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, including those responsible for capital schemes, for the areas that they are responsible for;
- investigation and reporting of variances from agreed budgets;
- monitoring of management action to correct variances and/or emerging adverse trends; and
- ensuring that adequate training is delivered on an on-going basis to budget holders.

Monitoring

4.16 The Director of Finance shall provide monthly reports in the form requested by the Cabinet Secretary showing the charge against the Board's resource limits on the last day of each month.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance, on behalf of the Board, shall prepare, certify and submit audited Annual Accounts to the SGHSCD in respect of each financial year in such a form as the SGHSCD may direct.

5.2 The Director of Finance will ensure that the Annual Accounts and financial returns are prepared in accordance with the Annual Accounts Manual as issued by SGHSCD together with the guidance contained in the Government Financial Reporting Manual (FReM), detailing the accounts and returns to be prepared, the accounting standards to be adopted and the timetable for submission to the SGHSCD.

5.3 The Audit Committee will ensure that the Annual Accounts are reviewed and submitted to the Board for formal approval and the Chief Executive will ensure that they are recorded as having been so presented. The Annual Accounts will be subject to statutory audit by the external auditor appointed by Audit Scotland.

5.4 The Director of Finance shall prepare a Financial Statement for inclusion in the Board's Annual Report, in accordance with relevant guidelines, for submission to Board members and others who need to be aware of the Board's financial performance.

5.5 The Board shall publish an Annual Report, in accordance with the Scottish Government's guidelines on local accountability requirements.

6. BANKING AND CASH HANDLING

6.1 The Director of Finance shall manage the Board's banking arrangements and advise the Board on the provision of banking services and operation of accounts. This advice shall take into account guidance/Directions issued from time to time by the Scottish Government.

6.2 The Director of Finance shall ensure that the banking arrangements operate in accordance with the Scottish Government banking contract (GBS) and the Scottish Public Finance Manual.

6.3 The Board shall approve the banking arrangements. No employee may open a bank account for the Board's activities or in the Board's name, unless the Board has given explicit approval.

6.4 The Director of Finance shall:-

- Establish separate bank accounts for non-exchequer funds;
- Ensure payments made from bank or GBS accounts do not exceed the amount credited to the account, except where arrangements have been made;
- Ensure money drawn from the Scottish Government against the Cash Requirement is required for approved expenditure only, and is drawn down only at the time of need;
- Promptly bank all monies received intact. Expenditure shall not be made from cash received that has not been banked, except under exceptional arrangements approved by the Director of Finance; and
- Report to the Board all arrangements made with the Board's bankers for accounts to be overdrawn.

6.5 The Director of Finance shall prepare detailed instructions on the operation of bank and GBS accounts, which must include:-

- The conditions under which each bank and GBS account is to be operated;
- Ensuring that the GBS account is used as the principal banker and that the amount of cleared funds held at any time within exchequer commercial bank accounts is limited to a maximum of £50,000 (of cleared funds).
- The limit to be applied to any overdraft;
- Those authorised to sign cheques or other orders drawn on the Board's accounts; and

- The required controls for any system of electronic payment.

6.6 The Director of Finance shall:-

- Approve the stationery for officially acknowledging or recording monies received or receivable, and keep this secure;
- Provide 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
- Approve procedures for handling cash and negotiable securities on behalf of the Board.

6.7 Money in the custody of the Board shall not under any circumstances be used for the encashment of private cheques.

6.8 The holders of safe keys shall not accept unofficial funds for depositing in their safes other than in exceptional circumstances. Such deposits must be 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.

7. SECURITY OF ASSETS

7.1 Overall responsibility for the security of the Board's assets rests with the Board's Chief Executive. All members and employees have a responsibility for the security of property of the Board and it shall be an added responsibility of senior staff in all disciplines to apply appropriate routine security practices in relation to NHS property. Any significant breach of agreed security practice should be reported to the Chief Executive.

7.2 Wherever practicable, items of equipment shall be marked as property of Highland NHS Board.

7.3 The Chief Executive shall define the items of equipment to be controlled, and officers designated by the Chief Executive shall maintain an up-to-date register of those items. This shall include separate records for equipment on loan from suppliers, and lease agreements in respect of assets held under a finance lease and capitalised.

7.4 The Director of Finance shall approve the form of register and the method of updating which shall incorporate all relevant requirements for capital assets.

7.5 Additions to the capital asset register must be added to the records based on the documented cost of the asset at the time of acquisition.

7.6 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 authorised documentation.

7.7 The value of each asset where applicable shall be indexed to current values and depreciated using methods and rates as suggested in the Capital Accounting Manual and notified by the SGHSCD.

7.8 Revaluation of land and buildings will be provided by the Board's recommended Valuation Agent on a rolling annual programme designed to ensure that all such assets are revalued once every five years.

7.9 Annual indexation for land and buildings not included in the revaluation exercise in any given year will be provided by the Board's recommended Valuation Agent.

7.10 Any damage to the Board's premises, vehicles and equipment, or any loss of equipment or supplies shall be reported by staff in accordance with the procedure for reporting losses.

8. PAY

Remuneration Committee

8.1 The Board shall approve the terms of reference for the Remuneration Committee, in line with any relevant guidance or requirements.

8.2 The Board shall remunerate the Chair and other non-executive directors in accordance with instructions issued by Scottish Government

Processes

8.3 The Chief Executive shall establish a system of delegated budgetary authority within which budget holders shall be responsible for the engagement of staff within the limits of their approved budget.

8.4 All time records, payroll timesheets and other pay records and notifications shall be in a form approved by the Director of Finance and shall be authorised and submitted in accordance with their instructions. This also includes e-expenses, SSTS and eESS.

8.5 The Director of Finance shall be responsible for ensuring that rates of pay and relevant conditions are applied in accordance with current agreements. The Chief Executive, or the Board in appropriate circumstances, shall be responsible for the final determination of pay. There will be no variation to agreed terms and conditions without the prior approval of the Director of Human Resources & Organisational Development and Director of Finance. The Director of Finance shall determine the dates on which the payment of salary and wages are to be made. These may vary due to special circumstances (e.g. Christmas and other Public Holidays). Payments to an individual shall not be made in advance of normal pay, except:

a. To cover a period of authorised leave, involving absence on the normal pay day; or

b. As authorised by the Director of Human Resources & Organisational Development or Director of Finance to meet special circumstances, and limited to the net pay due at the time of payment.

8.6 All employees shall be paid by bank credit transfer unless otherwise agreed by the Director of Finance.

8.7 The Board shall delegate responsibility to the Director of Human Resources & Organisational Development for ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation and any existing NHS policies.

9. NON PAY

Tendering, Contracting and Purchasing Procedures

9.1 The Director of Finance shall prepare detailed procedural instructions on the

obtaining of goods, services and works, incorporating thresholds set by the Board. The current Authorisation Limits are set out in Scheme of Delegation and the Financial Operating Procedures/Delegated level of Authority Matrix.

9.2 The Chief Executive shall designate a senior officer as the lead senior officer for procurement, and this person shall oversee the procurement of goods and services, to ensure there is an adequate approval of suppliers and their supplies based on cost and quality.

9.3 NSS National Procurement shall undertake procurement activity on a national basis on behalf of boards (including NHS Highland), and the Board shall implement these nationally negotiated contracts where appropriate.

9.4 The Board shall operate within the processes established for the procurement of publicly funded construction work.

9.5 The Board shall comply with Public Contracts (Scotland) Regulations 2012 (and any subsequent relevant legislation) for any procurement it undertakes directly.

9.6 The Director of Finance 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.

9.7 All other aspects of procurement activity must follow the requirements of the Standing Orders and SFIs. Any decision to depart from the requirements of this section must have the approval of NHS Highland Board.

9.8 The Director of Finance shall:-

- Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained in accordance with the Public Contracts (Scotland) Regulations, as issued annually through Scottish Statutory Instrument.
- Ensure the preparation of comprehensive procedures for all aspects of procurement activity.

9.9 The following basic principles shall be generally applied:-

- Procurement activity satisfies all legal requirements;
- Adequate contracts are in place with approved suppliers for the supply of approved products and services;
- Segregation of duties is applied throughout the process;
- Adequate approval mechanisms are in place before orders are raised;
- All deliveries are checked for completeness and accuracy, and confirmed before approval to pay is made; and
- All payments made are in accordance with previously agreed terms, and what the Board has actually received.

9.10 Limits of Authorisation of Orders

- Shall be in accordance with those designed officers contained with the DLA matrix.

9.11 Contract Implement and Tendering Matrix

THRESHOLD	PROCEDURE	ELECTRONIC SYSTEM
£OJEU threshold	OJEU Competitive Tender	PCS-Tender (Mandatory)
£50,000 – OJEU	Regulated Competitive Tender	PCS-Tender (Mandatory)
£10,000 - £49,999.99	Competitive Quotation (Minimum of 2)	PCS Quick Quote (Mandatory)
£1,000 - £9,999.99	One Written Quotation	
Under £1,000	No Requirement	

In the following exceptional circumstances, except in cases where EU Directives must be adhered to, the Director of Finance and Chief Executive, as specified in the Scheme of Delegation, can approve the waiving of the above requirements. Where goods and services are supplied on this basis and the value exceeds £10,000, a "Procurement Waiver Process Authorisation Form" may be granted by completing said form for approval by the appropriate director and the Head of Procurement. Where the purchase of goods and services on this basis exceeds £150,000, the completed form shall be endorsed by the Director of Finance and Chief Executive.

At least one of the following conditions must be outlined in the Procurement Waiver form:

1. where the repair of a particular item of equipment can only be carried out by the manufacturer;
2. where the supply is for goods or services of a special nature or character in respect of which it is not possible or desirable to obtain competitive quotations or tenders;
3. a contractors special knowledge is required;
4. where the number of potential suppliers is limited, and it is not possible to invite the required number of quotations or tenders, or where the required number do not respond to an invitation to tender or quotation to comply with these SFIs;
5. where, on the grounds of urgency, or in an emergency, it is necessary that an essential service is maintained or where a delay in carrying out repairs would result in further expense to NHS Highland.

In the case of 1, 2, 3, and 4 above, the form must be completed in advance of the order being placed, but may be completed retrospectively in the case of 5.

The Director of Finance will maintain a record of all such exceptions.

Where additional works, services or supplies have become necessary and a change of supplier/contractor would not be practicable (for economic, technical or interoperability reasons) or would involve substantial inconvenience and/or duplication of cost, an existing contractor may be asked to undertake additional works providing the additional works do not exceed 50% of the original contract value and are provided at a value for money cost which should normally be at an equivalent or improved rate to the original contract.

When goods or services are being procured for which quotations or tenders are not required and for which no contract exists, it will be necessary to demonstrate that value for money is being obtained. Written notes/documentation to support the case, signed by the responsible Budget Holder, must be retained for audit inspection.

Further detail on the ordering of goods and services and relevant documentation are set out in the Financial Operating Procedures.

The use of supplies within the Office of Government (OGC) framework agreements may negate the need for three competitive tenders. The use of this route must always be recorded. In all instances, the regulations in respect of Official Journal of the European Union (OJEU) must be followed.

9.12 No order shall be issued for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive.

9.13 Orders shall not be placed in a manner devised to avoid the financial thresholds specified by the Board within the Scheme of Delegation.

9.14 All procurement on behalf of the Board must be made on an official order on the approved e-Procurement systems, PECOS, JAC or Maximo.

9.15 The Board shall not make payments in advance of need. However payment in advance of the receipt of goods or services is permitted in circumstances approved by the lead senior officer for procurement. Examples of such instances are:-

- Items such as conferences, courses and travel, foreign currency transactions, where payment is to be made at the time of booking.

9.16 The Board shall not make payments in advance of need. However payment in advance of the receipt of goods or services is permitted in circumstances approved by the Director of Finance. Examples of such instances are:-

- Where payment in advance of complete delivery is a legal or contractual requirement, e.g. maintenance contracts, utilities, rates.
- Where payment in advance is necessary to support the provision of services/delivery of a project by external providers (e.g. grants to local authorities or voluntary bodies.)
- Purchases from petty cash shall be undertaken in accordance with relevant financial operating procedures.

Commissioning of Patient Services

9.17 The Director of Finance, jointly with the Deputy Chief Executive will ensure service agreements are in place with other healthcare providers for the delivery of patient services, ensuring the appropriate financial details are contained and clarity on reporting of performance, quality and safety issues.

9.18 The Director of Finance shall be responsible for maintaining a system for the payment of invoices in respect of patient services in accordance with agreed terms and national guidance and shall ensure that adequate financial systems are in place to monitor and control these.

Payment of Invoices

9.19 The Director of Finance shall be responsible for the prompt payment of all invoices. The Director of Finance shall publish the Board's performance in achieving the prompt payment targets in accordance with specified terms and national guidance.

9.20 The Director of Finance shall be responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by the Board. The system shall provide for authorisation by agreed delegated officers, a timetable and system for the payment of invoices and instruction to staff regarding handling,

checking and payment of invoices.

9.21 The Director of Finance shall ensure that payments for goods and services are made only after goods and services are received. Prepayments will be permitted in exceptional circumstances and with the prior approval of the Director of Finance

Additional Matters for Capital Expenditure

Overall Arrangements for the Approval of the Capital Plan

9.22 The Board shall follow any national instructions on the approval of capital expenditure, such as the Scottish Capital Investment Manual. The authorisation process shall be described in the Scheme of Delegation.

9.23 The Chief Executive shall ensure that:-

- there is an adequate appraisal and approval process in place for determining capital expenditure priorities within the Property Strategy and the effect of each proposal upon business plans;
- all stages of capital schemes are managed, and are delivered on time and to cost;
- capital investment is not undertaken without confirmation that the necessary capital funding and approvals are in place; and
- all revenue consequences from the scheme, including capital charges, are recognised, and the source of funding is identified in financial plans.

Implementing the Capital Programme

9.24 For every major capital expenditure proposal the Chief Executive shall ensure:-

- that a business case as required by the Scottish Capital Investment Manual (SCIM) is produced setting out:-
  a. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and
  b. appropriate project management and control arrangements; and
- that the Director of Finance has assessed the costs and revenue consequences detailed in the business case.

9.25 The approval of a business case and inclusion in the Board's capital plan shall not constitute approval of the individual elements of expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:-

- specific authority to commit expenditure; and
- following the required approval of the business case, authority to proceed to tender.

9.26 The Scheme of Delegation shall stipulate where delegated authority lies for:-

- approval to accept a successful tender; and
- where Frameworks Scotland applies, authority to agree risks and timelines associated with a project in order to arrive at a target price.

9.27 The Director of Finance shall issue procedures governing the financial management of capital investment projects (e.g. including variations to contract, application of

Frameworks Scotland) and valuation for accounting purposes.

Public Private Partnerships and other Non-Exchequer Funding

9.28 When the Board proposes to use finance which is to be provided other than through its capital allocations, the following procedures shall apply:-

- The Director of Finance shall demonstrate that the use of public private partnerships represents value for money and genuinely transfers significant risk to the private sector.
- Where the sum involved exceeds the Board's delegated limits, the business case must be referred to the Scottish Government for approval or treated as per current guidelines.
- Board must specifically agree the proposal.
- The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Disposals of Assets

9.29 The Director of Finance shall issue procedures for the disposal of assets including condemnations. All disposals shall be in accordance with MEL(1996)7: Sale of surplus and obsolete goods and equipment and in accordance with the Property Transaction Handbook.

9.30 There is a requirement to achieve Best Value for money when disposing of assets belonging to the Health Board. A competitive process should normally be undertaken.

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

9.32 All unserviceable articles shall be:-

- Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance.
- Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

Capital Accounting

9.33 The Director of Finance shall be notified when capital assets are sold, scrapped, lost or otherwise disposed of, and what the disposal proceeds were. The value of the assets shall be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

9.34 The Director of Finance shall approve procedures for reconciling balances on capital assets accounts in ledgers against balances on capital asset registers.

9.35 The value of each asset shall be indexed and depreciated in accordance with methods specified by the Capital Accounting Manual.

9.36 The Director of Finance shall calculate capital charges, which will be charged against the Board's revenue resource limit.

10. PRIMARY CARE CONTRACTORS

10.1 In these SFIs and all other Board documentation, Primary Care contractor means:-

- an independent provider of healthcare who is registered to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in the United Kingdom (UK); or
- an employee of an National Health Service organisation in the UK who is registered to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in the UK.

10.2 The relevant Primary Care Managers shall devise and implement systems to control the registers of those who are entitled to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in Highland and Argyll & Bute areas. Systems shall include criteria for entry to and deletions from the registers.

10.3 The Director of Finance shall agree the Service Level Agreement (s) with NHS National Services Scotland for:-

- the development, documentation and maintenance of systems for the verification, recording and receipt of NHS income collected by or on behalf of primary care contractors; and
- the development, documentation and maintenance of systems for the verification, recording and payment of NHS expenditure incurred by or on behalf of primary care contractors.

10.4 The agreements at paragraph 10.3 above shall comply with guidance issued from time to time by the Scottish Government. In particular they shall take account of any national systems for the processing of income and expenditure associated with primary care contractors.

10.5 The Director of Finance shall ensure that all transactions conducted for or on behalf of primary care contractors by the Board shall be subject to these SFIs.

11. INCOME

11.1 The Director of Finance shall be responsible for designing and maintaining systems for the proper recording and collection of all monies due.

11.2 The Director of Finance shall take appropriate recovery action on all outstanding debts and shall establish procedures for the write-off of debts after all reasonable steps have been taken to secure payment.

11.3 The Director of Finance is responsible for ensuring the prompt banking of all monies received.

11.4 In relation to business development/income generation schemes, the Director of Finance shall ensure that there are systems in place to identify and control all costs and revenues attributed to each scheme.

11.5 The Director of Finance shall approve all fees and charges other than those determined by the Scottish Government or by Statute.

12. FINANCIAL MANAGEMENT SYSTEM

12.1 The Director of Finance shall carry prime responsibility for the accuracy and security of the computerised financial data of the Board and shall devise and implement any necessary procedures to protect the Board and individuals from inappropriate use or misuse of any financial and other information held on computer files for which they are responsible, after taking account of all relevant legislation and guidance

12.2 The Director of Finance shall ensure that contracts for computer services for financial applications with another Board or any other agency shall clearly define the responsibility of all the parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage.

12.3 The Director of Finance shall ensure that adequate data controls exist to provide for security of financial applications during data processing, including the use of any external agency arrangements.

12.4 The Director of Finance should ensure that such computer audit checks as they may consider necessary are being carried out.

12.5 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and are thoroughly tested prior to implementation.

12.6 Where another health organisation or any other agency provides a financial system service to the Board, the Director of Finance shall periodically seek assurances, through Audit where appropriate, that adequate controls are in operation and that disaster recovery arrangements are robust.

13. CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Any employee or agent discovering or suspecting a loss of any kind shall forthwith inform their head of department, who shall immediately inform the Chief Executive and the Director of Finance. Where a criminal offence is suspected, the Director of Finance shall follow the Fraud Policy and Action Plan, as set out in the Financial Operating Procedures.

13.2 The Director of Finance shall notify the Audit Committee and Counter Fraud Services of all actual or suspected frauds. See 13.10 below.

13.3 In all instances where there is any suspicion of fraud then the guidance contained within NHS Circular, HDL (2005) 5: “Tackling Fraud in Scotland – Joint Action Programme. Financial Control: Procedures where criminal offences are suspected” must be followed. The Board’s Fraud Liaison Officer (FLO) must be notified immediately of all cases of fraud or suspected fraud.

13.4 The Director of Finance shall issue procedures on the recording of and accounting for Losses and special payments to meet the requirements of the Scottish Public Finance Manual. These procedures shall include the steps to be taken where the loss may have been caused by a criminal act.

13.5 The Scheme of Delegation shall describe the process for the approval of the write-off of losses and making of special payments

13.6 The Director of Finance shall maintain a Losses and Special Payments Register in which details of all Category 1 and Category 2 losses shall be recorded as they are known. Category 3 losses may be recorded in summary form. Write-off action shall

be recorded against each entry in the Register.

13.7 No special payments exceeding the delegated limits shall be made without prior approval by the SGHSCD.

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

13.9 The Director of Finance is required to produce a report on Condemnations, Losses and Special Payments, where the delegated limits have been exceeded and SGHSCD approval has been requested, to the Audit Committee.

13.10 The Bribery Act came into force in 2010; it aims to tackle bribery and corruption in both the private and public sectors. The Act is fully endorsed by Highland NHS Board. NHS Highland conducts its contracting and procurement practices with integrity, transparency and fairness and has a zero tolerance policy on bribery or any kind of fraud. There are robust controls in place to help deter, detect and deal with it. These controls are regularly reviewed in line with the Standing Financial Instructions and feedback is provided to the Audit Committee. Procurement actively engage with NHS Scotland Counter Fraud Services to ensure that our team is fully trained on spotting potential signs of fraud and knowing how to report suspected fraud. As an existing or potential contractor to NHS Highland, you are required to understand that it may be a criminal offence under the Bribery Act 2010, punishable by imprisonment, to promise, give or offer any gift, consideration, financial or other advantage whatsoever as an inducement or reward to any officer of a public body and that such action may result in the Board excluding the organisation from the selected list of Potential Bidders, and potentially from all future public procurements. It is therefore vital that staff, contractors and agents understand what is expected of them and their duties to disclose and deal with any instances they find.

14. RISK MANAGEMENT

14.1 The Chief Executive shall ensure that the Board has a programme of risk management, which will be approved and monitored by the Board and which complies with the Standards issued by NHS Health Improvement Scotland.

NHS Highland takes part in CNORIS (the Clinical Negligence and Other Risks Indemnity Scheme), a not for profit, mutual Scheme providing a pool of funds to meet financial claims on the NHSS, which provides cover for both clinical and non-clinical claims against NHS Highland.

NHS Highland retains the services of legal advisors, primarily the Central Legal Office who liaise with the Clinical Governance Team regarding claims and inform NHS Highland about the best course of action to take in each case.

14.2 The programme of risk management shall include:

a. A process for identifying and quantifying risks and potential liabilities, including the establishment and maintenance of a Risk Register;

b. Encouraging a positive attitude towards the control of risk among all levels of staff;

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;

e. Audit arrangements including internal audit, clinical audit and health and safety

review;

f. Arrangements to review the risk management programme.

g. A review by each Governance Committee of relevant risks pertaining to their business.

The existence, integration and evaluation of the above elements will provide a basis for the Risk Committee to make a statement on the overall effectiveness of Internal Control and Corporate Governance to the Board.

14.3 The programme of risk management will be underpinned by a Board Assurance Framework, approved, and reviewed annually by the NHS Board.

15. RETENTION OF DOCUMENTS

15.1 The Chief Executive shall be responsible for maintaining archives for all documents in accordance with the NHS Code of Practice on Records Management.

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

15.3 Documents held under the Code shall only be destroyed at the express instigation of the Chief Executive, and records shall be maintained of documents so destroyed.

16. PATIENTS'/CLIENTS' PROPERTY AND FUNDS

16.1 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, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive shall be responsible for ensuring that patients/client or their guardians, as appropriate, are informed before, or at their admission, by: -

- Notices and information booklets
- Hospitals'/Care facilities admission documentation and property records, and
- The oral advice of administrative and nursing staff responsible for admissions, that the Board will not accept responsibility or liability for patients'/clients' monies and personal property brought into Board premises unless it is handed in for safe custody and a copy of an official property record is obtained as a receipt.

16.3 The Director of Finance shall provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients'/clients' property (including instructions on the disposal of the property of deceased patients/clients and patients/clients transferred to other premises), for all staff whose duty it is to administer, in any way, the property of the patients/clients.

16.4 Bank accounts for patients'/clients' monies shall be operated under arrangements agreed by the Director of Finance.

16.5 A property record, in a form determined by the Director of Finance, shall be completed.

16.6 The Director of Finance is responsible for providing detailed instructions on the Board's responsibility as per the Adults with Incapacity (Scotland) Act 2000 and the updated Part 5 in CEL11(2008) Code of Practice. These instructions are contained within the Financial Operating Procedures.

16.7 The Director of Finance shall prepare an abstract of receipts and payments of patients/clients private funds in the form laid down by Scottish Government.

17. STORES

17.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use), should be:-

- Kept to a minimum;
- Subject to annual stocktake; and
- Valued at the lower of cost and net realisable value.

17.2 Subject to the responsibility of the Director of Finance for the systems of control, the control of stores throughout the organisation shall be the responsibility of the relevant managers. The day-to-day management may be delegated to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance.

17.3 The responsibility for security arrangements, and the custody of keys for all stores locations, shall be clearly defined in writing by the manager responsible for the stores and agreed with the Director of Finance. Wherever practicable, stock items, which do not belong to the Board, shall be clearly identified.

17.4 All stores records shall be in such form and shall comply with such system of control and procedures as the Director of Finance shall approve.

17.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one officer other than the Storekeeper, and the Director of Finance and Internal and External Audit shall be notified and may attend, or be represented, at their discretion. The stocktaking records shall be numerically controlled and signed by the officers undertaking the check. Any surplus or deficiency revealed on stocktaking shall be reported immediately to the Director of Finance, and they may investigate as necessary. Known losses of stock items not on stores control shall be reported to the Director of Finance.

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

17.7 Instructions for stock take and the basis for valuation will be issued at least once a year by the Director of Finance.

18. AUTHORISATION LIMITS

18.1 The purpose of Standing Financial Instructions is to ensure adequate controls exist for the committing and payment of funds on behalf of NHS Highland. The main principles applied in determining authorisation limits are those of devolved accountability and responsibility. The rules for financial delegation to all levels of management within the Board's established policies and priorities are set out in the Scheme of Delegation and Financial Operating Procedures

18.2 Areas covered by the Scheme of Delegation include:

- Limitation and Authority to vire budgets between one budget heading and another.

- Limitation of level of Authority for the placing of orders or committing resources
- Limitation as to the level of authority to approve receipt of orders, expenses, travel claims, payment of invoices, write off of losses.

19. ENDOWMENT FUNDS

19.1 The Standing Financial Instructions deal with matters related to exchequer income and expenditure for NHS Highland. Whilst Endowment Funds fall outwith the scope of core exchequer funds, it is important that all relevant employees and agents are aware of the arrangements for the financial responsibility and authority for such funds.

19.2 Endowment Funds and are those held in trust for purposes relating to the National Health Service, either by the Board or Special Trustees appointed by the Scottish Ministers or by other persons.

19.3 Members of the Highland Health Board become Trustees of the Board's Endowment Funds. The responsibilities as Trustees are discharged separately from the responsibilities as members of the Board.

19.4 The Director of Finance shall prepare detailed procedural instructions covering the receiving, recording, investment and accounting for Endowment Funds.

19.5 Through the Board's Scheme of Delegation, authority will be given by the Trustees to allow for the day to day management of the funds within specified limits.

19.6 The Authorisation Limits are set out in the Scheme of Delegation and the Financial Operating Procedures.

19.7 The Director of Finance shall prepare annual accounts for the funds held in trust, to be audited independently and presented annually to the trustees.

20. JOINT VENTURES

20.1 Prior to entering into a joint venture (JV) the Board will conduct due diligence to identify whether the JV has or will have in place anti-bribery policies and procedures that are consistent with its own.

20.2 Where the Board has overall control of the JV it should ensure that the JV has anti-bribery controls in place that are consistent with the Board's own policies and procedures.

20.3 Where the Board does not have overall control of the JV it will inform the JV organisations of its policy and procedures and encourage them to adopt these for the venture.

20.4 Where due diligence shows that the JV does not have appropriate anti-bribery policies and procedures in place consistent with its own, the Board should ensure that it is protected from litigation arising from acts of bribery by partner organisations in the wording of any contract or agreement. Central Legal Office advice and guidance should be obtained to ensure that the Board is fully protected.

20.5 The Board should monitor the programmes and performance of its JV partners in respect of anti-bribery. Anti-bribery should be a standing agenda item on JV meetings and reports should be tabled demonstrating adherence to policy and procedures, identification of any acts of bribery or potential bribery and management actions taken and proposed.

20.6 Where the Board determines that the JV policies and practices are inconsistent with its own, the Board will take appropriate action. This may involve insistence by the Board of adoption of appropriate policy and procedures by the JV, putting in place legal protection for the Board, where the partners indemnify the Board against acts of bribery or ultimately withdrawal of the Board from the JV.

20.7 Where the Board is unable to ensure that a JV has anti-bribery policy and procedures consistent with its own, it will ensure that it has a plan to exit from the arrangement if bribery occurs or may be reasonably thought to have occurred. Central Legal Office advice and guidance should be sought to ensure that such arrangements are in place in any legal documentation.

SECTION D

RESERVATION OF POWERS
AND
SCHEME OF DELEGATION

Draft for consideration by the Board – September 2020

CONTENTS

1. SCHEDULE OF MATTERS RESERVED FOR BOARD APPROVAL

1.1 THE BOARD'S RESPONSIBILITIES

In accordance with Scottish Government guidance (NHS Circular HDL (2003)11), the NHS Board is a board of governance.

The Board has a corporate responsibility for ensuring that arrangements are in place for the conduct of its affairs and that of its component parts, including compliance with applicable guidance and legislation, and ensuring that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively. The Board has an ongoing responsibility to ensure that it monitors the adequacy and effectiveness of these arrangements in practice.

The Board is required to ensure that it conducts a review of its systems of internal control, including in particular its arrangements for risk management, at least annually.

NHS Highland Board operates under the Public Bodies (Joint Working) (Scotland) Act 2014 ('the Act') and associated regulations for delivery of integrated functions across the Board area. In accordance with the Act, the parties to the Highland Partnership Integration Scheme (Highland Council and NHS Highland) have agreed the delegation of functions to a Lead Agency model of delivery for services covering Highland Council's geographic area. The parties to the Argyll and Bute Integration Scheme (Argyll and Bute Council and NHS Highland) have agreed to the delegation of functions to an Integration Joint Board model of delivery.

1.2 MATTERS RESERVED FOR BOARD DECISIONS AND/OR APPROVAL

The Standing Orders for the proceedings and Business of NHS Highland Board include a section on Matters Reserved for the Board (Paragraph 6). This section of the Standing Orders states that the following matters shall be reserved for approval by the Board:

n) Standing Orders
o) The establishment and terms of reference of all its committees, and appointment of committee members
p) Organisational Values
q) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
r) 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.)
s) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
t) Risk Management Policy.
u) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
v) Standing Financial Instructions and a Scheme of Delegation.
w) Annual accounts and report. (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.)
x) 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.

y) The Board shall approve the content, format, and frequency of performance reporting to the Board.

z) 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.)

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.

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

2 MATTERS DELEGATED TO COMMITTEES

Paragraph 7 of the Board's Standing Orders identifies that other "matters" may be delegated to Committees on behalf of the Board.

The following sets out NHS Highland's Committees' delegated responsibility on behalf of the Board

2.1 Audit Committee	
Responsible Director for this Section	Director of Finance
Role and Remit	The role of the Committee is: • To ensure the management of the Board's activities is in accordance with the regulations governing the NHS in Scotland that an effective system of internal control is maintained and that a strong corporate governance culture is in operation. The duties of the Audit Committee shall be in accordance with the Scottish Government Audit & Assurance Handbook, dated March 2018. • To approve and monitor the delivery of the internal audit plans. • To ensure a system of internal control is in existence and maintained to give reasonable assurance that assets are safeguarded; waste or inefficiency is avoided; risk management is in place; reliable financial information is produced. • To support the Board and Accountable Officer in their responsibilities through a process of constructive challenge which focuses on both processes and outcomes. The main objective of the Audit Committee is to support the Accountable Officer and NHS Highland Board in meeting their assurance needs. This includes advising the Board and Accountable Officer on: • The strategic processes for risk, control and governance and the Statement on Internal Control • The effectiveness of the internal control environment • Assurances relating to the corporate governance requirements of the organisation • Determining the planned activity and results of internal audit reviews and reports • The adequacy of management response to issues identified by all audit activity, including the external audit's management letter/report • The accounting policies, the accounts and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of errors identified and management's letter of representation to the external auditors • Anti-fraud policies, whistle-blowing processes and arrangements for special investigation • To support organisational and financial performance and efficiency as well as the effectiveness and quality of services

2.2 Clinical Governance Committee	
Responsible Director for this Section	Medical Director
Sub-Committees	• NHSH Quality and Patient Safety Groups • Argyll and Bute Clinical & Care Governance Committee • Control of Infection Committee • Information Assurance Group • Area Drug & Therapeutics Committee • Transfusion Committee • Organ and Tissue Donation Committee
Role and Remit	To carry out the statutory duties as outlined in NHS MEL(1998~)75, NHS MEL (2000)29 and NHS MEL (2001)74. To give the Board assurance that clinical and care governance systems are in place and working throughout the organisation. To provide assurance that decision making about the planning, provision, organisation and management of services which are the responsibility of the Board takes due cognisance of the quality and safety of care and treatment. To support the development and implementation of a Clinical and Care Strategy which fits with national strategies, takes into account local population needs and demographics, and is geared towards quality, sustainable community and acute services. The remit of the Clinical Governance Committee is to: • To interrogate the clinical and care governance systems to ensure that the principles and standards for clinical governance are being implemented. • To challenge evidence gathered across the organisation to raise areas of concern, ensure that these are properly addressed, and to monitor and review the effect of actions taken and report outcomes to the Board. • To review outcomes against local and national standards and to ensure compliance with national regulatory and performance requirements. • To select clinical quality targets and outcomes and ensure an appropriate audit and reporting framework is adhered to across the organisation. • To receive exception reports from its reporting committees on relevant areas of concern and the submission of action plans of amended practice. • To receive reports from its reporting committees. • To receive regular reports from the Quality and Patient Safety Groups on the implementation of the quality & patient

	safety framework and on an agreed range of quality targets and outcomes. To receive a clinical risk register on a quarterly basis for consideration by the Committee.

2.3 Finance, Performance and Resources Committee	
Responsible Director for this Section	Director of Finance
Sub-Committees	• Asset Management Group • Financial Recovery Board • Performance Recovery Board
Role and Remit	The purpose of the Committee is to keep under review the financial position and performance against key finance and non-financial targets of the Board, and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that the arrangements are working effectively. **ROLE** To scrutinise the overall performance of NHS Highland across the following functions of the NHS Board: • Resource allocation; • Performance management; • Strategic planning. To ensure that systems and procedures are in place to monitor, manage and improve performance, across the whole system, and liaise closely with relevant Governance Committees (Staff, Clinical and Audit) to ensure appropriate remedial action takes place. To consider financial plans, and approve annual budget proposals and business cases for submission to the NHS Board. **REMIT** The Committee shall have accountability to the Board for ensuring that the financial position of the Board is soundly based, having regard to: • compliance with statutory financial requirements and achievement of financial targets; • such financial monitoring and reporting arrangements as may be specified from time-to-time by Scottish Government Health & Social Care Directorates and/or the Board; • the impact of planned future policies and known or foreseeable future developments on the financial position; • Highland's overall performance, strategic policy and planning objective, and ensure mechanisms are in place to promote best value improved efficiency and effectiveness • ensuring a rigorous and systematic approach to performance monitoring and reporting is in place to enable more strategic and

	better informed discussions to take place at NHS Highland Board meetings • review regularly the sections of the NHS Highland Integrated Performance Report relevant to the Committee's responsibility. • recommend the annual revenue and capital budgets, and financial plans consistent with its statutory financial responsibilities; • review the Property Strategy (including the acquisition and disposal of property) and capital plans, and make recommendations to the Board. • the regular review of NHS Highland's Business Continuity Plan and; • oversight of emergency planning arrangements. • scrutiny of relevant financial and performance risks on the Corporate Risk register on a bi-monthly basis. • undertake an annual self-assessment of the Committee's work and effectiveness **Arrangements for Securing Value for Money** The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for (a) planning, appraisal, control, accountability and evaluation of the use of resources, and for (b) reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review action (proposed or underway) to ensure that the Board achieves financial balance in line with statutory requirements. **Allocation and Use of Resources** The Committee has key responsibilities for: • reviewing the development of the Board's Financial Strategy in support of the Annual Operational Plan, and recommending approval to the Board; • reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the Board thereon; • monitoring the use of all resources available to the Board; and • reviewing all matters relating to Best Value. Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment) and the review of the Property Strategy (including the acquisition and disposal of property), and for making recommendations to the Board as appropriate on any issue within its terms of reference. **Performance** To support the development of a performance management and accountability culture across NHS Highland. Receive annual reports and quarterly updates from the Sub-committees

	established by the Committee in order to provide assurance and accountability. To monitor and review risks falling within its remit.

2.4 Highland Health and Social Care Committee	
Responsible Director for this Section	Chief Officer (North Highland)
Sub-Committees	
Role and Remit	

2.5 Remuneration Committee	
Responsible Director for this Section	Director of HR and OD
Sub-Committees	None
Role and Remit	The purpose of the Remuneration Committee is: • To consider and agree performance objectives and performance appraisals for staff in the Executive cohort and to oversee performance arrangements for designated senior managers. The Committee will be responsible for applying the remit detailed in NHS: MEL (2000) 25, NHS HDL (2002) 64 and subsequent guidance. • To direct the appointment process for the Chief Executive and Executive Members of the Board. The remit of the Committee is to: • Agree all the terms and conditions of employment of Executive Directors and Senior Managers of the Board, including - job descriptions - job evaluation - terms of employment - basic pay - performance related pay - benefits (removal arrangements and cars) • Agree objectives for executives before the start of the year in which performance is assessed • Ensure that effective arrangements are in place for carrying out the above two functions in respect of all other senior managers • Conduct a regular review of the Board's policy for the remuneration and performance assessment of executive directors, other senior managers and medical consultants, in the light of guidance issued by the SGHD and any specific National, External or Internal Audit Report. The Remuneration Committee, under the leadership of the Chair will: • Ensure Remuneration Sub-Committee members are fully trained to undertake Committee member duties. • Ensure efficient and effective use of public monies in relation to managerial and executive pay. • Ensure that decisions on pay are fully supportable and auditable. • Ensure that individual targets and assessments of performance against targets are tied to the Board's overall performance in providing health and social care services. • Take full account of Government policy on pay in the public sector and the need to contain overall management costs when determining pay increases.

2.6 Staff Governance Committee	
Responsible Director for this Section	Director of Human Resources and Organisational Development
Sub-Committees	• Health and Safety Committee • Highland Partnership Forum • Culture Programme Board
Role and Remit	The purpose of the Staff Governance Committee is to support and maintain a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration. It will ensure that robust arrangements to implement the Staff Governance Standard are in place and monitored To assure the Board that the staff governance arrangements across NHS Highland are working effectively. As a Committee of the Board, escalate any issues if serious concerns are identified regarding staff governance issues within NHS Highland. The remit of the Committee is to: • Consider NHS Highland's performance in relation to its achievements of effective Staff Governance and its compliance with the Staff Governance Standard; • Give assurance to the Board on the operation of Staff Governance systems within NHS Highland, identifying progress, issues and actions being taken, where appropriate; • Oversee the commissioning of structures and processes which ensure that the delivery against the standard is being achieved • Monitor and evaluate strategies and implementation plans relating to people management • Approve any policy amendment, funding or resource submission to achieve the Staff Governance Standard • Take responsibility for the timely submission of all staff governance information required for national monitoring arrangements • Review action taken on recommendations made by the Committee, NHS Boards, or the Scottish Ministers on Staff Governance matters; • Provide assurance and oversight to the board for the operation of the Highland Partnership Forum, the Health & Safety Sub Committee and the Culture Oversight Group and escalate any matters as required. • Support the operation of the Highland Partnership Forum and the Local Partnership Forums in their Staff Governance monitoring role and the appropriate flow of information to facilitate this; • Undertake an annual self-assessment of the Committee's work and effectiveness and share with Scottish Government.

2.7 Pharmacy Practices Committee	
Responsible Director for this Section	Medical Director
Role and Remit	The Pharmacy Practices Committee is required to consider applications to provide pharmaceutical services within the Board area and to determine whether the application will be granted. The remit of the Committee is to: • Under Regulation 5(10) of the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009, as amended, the Committee will grant the application if it is satisfied that the provision of pharmaceutical services, at the identified premises, is necessary or desirable in order to secure adequate provision of pharmaceutical services in the neighbourhood in which the proposed premises are located unless the PPC considers that the provision of existing services would be prejudiced by the granting of the application to the extent where either primary medical services or pharmaceutical services may no longer be sustainable or secure within a controlled locality, then they must refuse the application. • The factors which need to be considered include: a) What is the neighbourhood in which the premises are located? b) What are the existing services in the neighbourhood? c) Are these services adequate or not? d) Is it necessary to grant the application in order to secure adequate provision of pharmaceutical services in the neighbourhood? e) Is it desirable to grant the application in order to secure adequate provision of pharmaceutical services in the neighbourhood? In order to consider these questions the following information will include, where necessary: • The location of the premises, the geography of the area and the social factors which may create boundaries. • What services already are provided by other contractors in the area, for example, other pharmacies, GP and dental practices? • What are the transport patterns and how do people travel? • The number of people who require services? • What services are provided during what hours? • The manner in which the application is considered shall be a matter for the Committee to determine. However, in most circumstances an oral hearing will be held to ensure that all members understand the evidence and that points of clarification can be obtained from the applicant or other parties. Wherever possible, the Committee will convene its meetings in the area local to the proposed premises and will undertake a site visit to obtain, first hand, knowledge of the local area and of the proposed premises.

3 MATTERS DELEGATED TO COMMITTEES AND TO INDIVIDUALS

Paragraph 7 of the Board's Standing Orders identifies that other matters may be delegated to individuals to act on behalf of the Board.

The following sets out matters delegated to individuals

3.1 INTERPRETATION

- Any reference in this scheme to a statutory or other provision shall be interpreted as a reference to that provision as amended from time to time by any subsequent legislation.

- Any power delegated to a nominated or specified officer in terms of this scheme may be exercised by such an officer or officers of his or her department as the officer may authorise.

- This Scheme of Delegation should be read in conjunction with the Board Standing Orders, Standing Financial Instructions, and Delegated Levels of Authority.

3.2 CHIEF EXECUTIVE

3.2.1 General Provisions

In the context of the Board's principal role to protect and improve the health of Highland residents and social care provision for adults, the Chief Executive as Accountable Officer shall have delegated authority and responsibility to secure the economical, efficient and effective operation and management of Highland NHS Board and to safeguard its assets:

- in accordance with the statutory requirements and responsibilities laid upon the Chief Executive as Accountable Officer for Highland NHS Board;
- in accordance with direction from the Scottish Government Health Department;
- in accordance with the current policies of and decisions made by the Board;
- within the limits of the resources available, subject to the approval of the Board; and
- in accordance with Standing Orders and Standing Financial Instructions.

The Chief Executive is authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chair and the Vice-Chair of the Board, and the relevant Standing Committee Chair. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Standing Committees to the Chief Executive, shall be reported to the Board or appropriate Standing Committee as soon as possible thereafter.

The Chief Executive is authorised to give a direction in special circumstances that any officer shall not exercise a delegated function subject to reporting on the terms of the direction to the next meeting of the appropriate Committee.

The Chief Executive has personal statutory accountability for all Health and Safety matters within NHS Highland.

The Chief Executive is empowered to take all steps necessary to assist the Board to develop, promote and monitor compliance with Standing Orders and Standing Financial Instructions, and appropriate guidance on standards of business conduct.

3.2.2 Finance

Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Chief Executive, after taking account of the advice of the Director of Finance. The Chief Executive acting together with the Director of Finance has delegated authority to approve the transfer of funds between budget heads, including transfers from reserves and balances.

The Chief Executive shall report to the Finance, Performance and Resources Committee those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest.

The Chief Executive may, acting together with the Director of Finance, and having taken all reasonable action to pursue recovery, approve the writing-off of losses, subject to the financial limits and categorisation of losses laid down from time to time by the Scottish Government Health and Social Care Directorates.

3.2.3 Legal Matters

The Chief Executive is authorised to institute, defend or appear in any legal proceedings or any inquiry, including proceedings before any statutory tribunal, board or authority, and following consideration of the advice of the Central Legal Office of the National Services Scotland (NSS), to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests.

In circumstances where a claim against the Board is settled by a decision of a Court, and the decision is not subject to appeal, the Chief Executive shall implement the decision of the relevant Court on behalf of the Board.

In circumstances where the advice of the Central Legal Office is to reach an out-of-court settlement, the Chief Executive may, acting together with the Director of Finance, settle claims against the Board, and thereafter being noted by the Audit Committee as part of the year end accounts and subject to a report thereafter being submitted to the Finance, Performance and Resources Committee.

The Chief Executive, acting together with the Director of Finance, may make ***ex-gratia*** payments subject to the limits laid down from time to time by the Scottish Government Health & Social Care Directorates.

The arrangements for signing of documents in respect of matters covered by the Property Transactions Handbook shall be in accordance with the direction of Scottish Ministers. The Chief Executive and the Director of Finance are currently authorised to sign such documentation on behalf of the Board and Scottish Ministers.

The Chief Executive shall have responsibility for the safe keeping of the Board's Seal, and together with the Chair or other nominated non-executive member of the Board, shall have responsibility for the application of the Seal on behalf of the Board.

3.2.4 Procurement of Supplies and Services

The Chief Executive shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders.

Where post tender negotiations are required, the Chief Executive shall nominate in writing, officers and/or agents to act on behalf of the Board.

The Chief Executive, acting together with the Director of Finance, has authority to approve on behalf of the Board the acceptance of tenders, submitted in accordance with the Board's Standing Orders, up to a value of £50,000,000, within the limits of previously approved Revenue and Capital Budgets, where the most economically advantageous tender is to be accepted.

The Chief Executive, through the Director of Finance, shall produce a listing, including specimen signatures, of those officers or agents to whom he/she has given delegated authority to sign official orders on behalf of the Board.

3.2.5 Human Resources

The Chief Executive may appoint staff in accordance with the Board's Standing Orders, Human Resources Policies and Delegated Levels of Authority.

The Chief Executive may, after consultation and agreement with the Director of Human Resources and Organisational Development, and the relevant Director/ Officer, amend staffing establishments in respect of the number and grading of posts. In so doing, the Director of Finance must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit approved by the Board for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to workforce planning, approved by the Board or Staff Governance Committee.

The Chief Executive has delegated authority from Highland NHS Board to approve the establishment of salaried dentist posts within NHS Highland, within the systematic approach as laid down by the Scottish Government Health & Social Care Directorate's Circular No PCA(D)(2005)3.

The Chief Executive may attend and may authorise any member of staff to attend within and outwith the United Kingdom conferences, courses or meetings of relevant professional bodies and associations, provided that:

- attendance is relevant to the duties or professional development of such member of staff; and
- appropriate allowance has been made within approved budgets; or
- external reimbursement of costs is to be made to the Board
- Under the terms of the public sector reform act the Chief Executive is required to keep a register of all such approvals

The Chief Executive may, in accordance with the Board's agreed Employee Conduct Policy, take disciplinary action, in respect of members of staff, including dismissal where appropriate.

The Chief Executive shall have overall responsibility for ensuring that the Board complies with Health and Safety legislation, and for ensuring the effective implementation of the Board's policies in this regard.

The Chief Executive may, in consultation with the Director of Human Resources and Organisational Development, and Director of Finance, approve applications to leave the employment of the Board on grounds of redundancy and/or early retirement by any employee provided the terms and conditions relating to the redundancy and/or early retirement are in accordance with the relevant Board policy. All such applications and outcomes will be reported to the Remuneration Committee.

3.2.6 Patients & Clients Valuables

The Chief Executive shall have overall responsibility for ensuring that the Board complies with legislation in respect of patients/clients' valuables. The term 'valuables' shall mean all assets other than land and buildings. (e.g. furniture, pictures, jewellery, bank accounts, shares, cash.)

3.2.7 Chief Executive Responsibility for Clinical Governance

The Chief Executive is responsible to the NHS Board for delivering clinical governance, and for ensuring that suitable local arrangements are in place and are integrated with existing structures such as clinical directorates. In this role, the Chief Executive has delegated overall responsibility for Clinical Governance to the Medical Director, working closely with the Director of Nursing. The Chief Executive remains responsible for reporting to the Board, and for taking any action it decides.

3.2.8 Chief Executive Responsibility for Risk Management

The Chief Executive has responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, set by Scottish Ministers, whilst safeguarding the public funds. This is achieved by the reporting through the NHS Board of all relevant information, including performance against objectives. The performance management arrangements operate within an environment of active risk management.

3.3 DIRECTOR OF FINANCE

Authority is delegated to the Director of Finance to take the necessary measures as undernoted, in order to assist the Board and the Chief Executive in fulfilling their corporate responsibilities:

3.3.1 Accountable Officer

The Director of Finance has a general duty to assist the Chief Executive in fulfilling his/her responsibilities as the Accountable Officer of the Board.

3.3.2 Financial Statements

The Director of Finance is empowered to take all steps necessary to assist the Board to:

- Act within the law and ensure the regularity of transactions by putting in place systems of internal control to ensure that financial transactions are in accordance with the appropriate authority;
- Maintain proper accounting records; and
- Prepare and submit for External Audit timeous financial statements which give a true and fair view of the financial position of the Board and its income and expenditure for the period in question.

3.3.3 Corporate Governance and Management

The Director of Finance is authorised to put in place proper arrangements to ensure that the financial position of the Board is soundly based by ensuring that the Board, its Committees, and supporting management groupings receive appropriate, accurate and timely information and advice with regard to:

- The development of financial plans, budgets and projections;
- Compliance with statutory financial requirements and achievement of financial targets;
- The impact of planned future policies and known or foreseeable developments on the Board's financial position.

The Director of Finance is empowered to take steps to ensure that proper arrangements are in place for:

- Developing and implementing systems of internal control, including systems of financial, operational and compliance controls and risk management;
- Developing and implementing strategies for the prevention and detection of fraud and irregularity;
- Internal Audit;
- Determining the level of expenses for patients travel and accommodation; and
- Determining the level of expenses for advisors to Board Committees.

3.3.4 Performance Management

The Director of Finance is authorised to assist the Chief Executive to ensure that suitable arrangements are in place to secure economy, efficiency, and effectiveness in the use of resources and that they are working effectively. These arrangements include procedures:

- for planning, appraisal, authorisation and control, accountability and evaluation of the use of resources;
- to ensure that performance targets and required outcomes are met and achieved.

3.3.5 Banking

The Director of Finance is authorised to oversee the Board's arrangements in respect of accounts held in the name of the Board with the Government Banking Service and the commercial bankers duly appointed by the Board.

The Director of Finance will be responsible for ensuring that the Government Banking Service and the commercial bankers are advised in writing of amendments to the panel of nominated authorised signatories.

3.3.6 Patients' and Clients' Valuables

The Director of Finance shall have delegated authority to ensure that detailed operating procedures in relation to the management of the valuables of patients' and clients' (including the opening of bank accounts where appropriate) are compiled for use by staff involved in the management of patients' and clients valuables and financial affairs, in line with the terms of the Adults with Incapacity (Scotland) Act 2000.

HEADS OF FINANCE

The Deputy Director of Finance and Finance Officer(s) designated as lead on financial matters for the Corporate Directorates and Operational Units have a general duty to assist the Chief Executive in fulfilling his/her responsibilities as the Accountable Officer of the Board.

Authority is delegated to the Deputy Director of Finance and Heads of Finance to take the necessary measures as undernoted to assist Corporate Directorates and Operational Units, their respective Committees, and Executive Directors, Operational Directors and Chief Officers in fulfilling their corporate responsibilities. In exercising these delegated powers the designated Finance Officer is also acting as the Director of Finance's representative.

3.3.7 Financial Statements

The Deputy Director of Finance and Finance Officer(s) are empowered to take all steps necessary for the Board to:

- act within the law,
- ensure the regularity of transactions by maintaining approved systems of internal control to ensure that financial transactions are in accordance with the appropriate authority,
- maintain proper accounting records; and
- ensure (by participation) the timeous completion of the Board's Annual Accounts.

3.3.8 Corporate Governance and Management

The Deputy Director of Finance and Finance Officer(s) are authorised to put in place proper arrangements to ensure that the financial position of the Board's Operational Units/Corporate Directorates is soundly based by ensuring that the governance Committees and supporting management groups receive appropriate, accurate and timely information and advice with regard to:

- the development of financial plans, budgets and projections,
- compliance with statutory financial requirements and achievement of financial targets, and

- the impact of planned future policies and known or foreseeable developments on the Operational Units/Corporate Directorates' financial position.

The Deputy Director of Finance and Finance Officer(s) is empowered to take steps to ensure that proper arrangements are in place for:

- monitoring compliance with the Board's Standing Orders and Standing Financial Instructions, and appropriate guidance on Standards of Business Conduct,
- contributing to the development and promotion of the Board's Standing Orders and Standing Financial Instructions,
- developing and implementing systems of internal control, including systems of financial, operational and compliance controls and risk management, and
- developing and implementing strategies for the prevention and detection of fraud and irregularity.

3.3.9 Performance Management

The Deputy Director of Finance and Finance Officer(s) are authorised to assist Executive Directors, Operational Directors and Chief Officers to ensure that suitable arrangements are in place to secure economy, efficiency, and effectiveness in the use of resources and that they are working effectively. These arrangements include procedures:

- for planning, appraisal, authorisation and control, accountability and evaluation of the use of resources, and
- to ensure that performance targets and required outcomes are met and achieved.

3.3.10 Patients' & Clients' Valuables

The Director of Finance shall have delegated authority to provide detailed operating procedures in relation to the management of the valuables of patients and clients (including the opening of bank accounts where appropriate) for use by staff involved in the management of patient's and clients valuables and financial affairs, in line with the terms of the Adults with Incapacity Act 2000.

3.4 PROVISIONS APPLICABLE TO EXECUTIVE DIRECTORS OF NHS HIGHLAND BOARD

3.4.1 The Executive Directors of the Board shall have delegated authority and responsibility from the Board Chief Executive to secure the economical, efficient and effective operation and management of their respective Directorates, Operational Units and Corporate Services and to safeguard their assets:

- in accordance with the current policies and decisions made by the Board;
- within the limits of the resources made available to their respective Directorates, Operational Units, or Corporate Services by the Board;
- in accordance with the Board's Standing Orders and Standing Financial Instructions; and
- in accordance with the relevant Scheme of Establishment.

The Executive Directors of the Board have a general duty to assist the Chief Executive in fulfilling his/her responsibilities as the Accountable Officer of the Board.

The Executive Directors of the Board are authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chair or the Vice-Chair of the Board, the Chief Executive and where appropriate the relevant Standing Committee Chair. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Standing Committees to the Chief Executive and consequently the Executive Directors of the Board, shall be reported to the Board or appropriate Standing Committee as soon as possible thereafter.

The Executive Directors of the Board are authorised to give a direction in special circumstances that any officer within the Operational Units shall not exercise a delegated function subject to reporting on the terms of the direction to the next meeting of the relevant Governance Committees.

3.4.2 Finance

Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Executive Directors of the Board, after taking account of the advice of the Director of Finance. The Executive Directors of the Board acting together with the designated Finance Officer have delegated authority to approve the transfer of funds between budget heads, including transfers from reserves and balances, up to a maximum of £500,000 in any one instance. The Executive Directors of the Board shall report to the Finance, Resources and Performance Committee and to the Chief Executive those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest.

The Executive Directors of the Board may, acting together with the Director of Finance, and having taken all reasonable action to pursue recovery, approve the writing-off of losses in the Operational Units subject to the financial limits and categorisation of losses laid down from time to time by the Scottish Government Health Department.

3.4.3 Legal Matters

The Executive Directors of the Board are authorised to institute, defend or appear in any legal proceedings or any inquiry, (including proceedings before any statutory tribunal, board or authority) in respect of the Operational Units and following consideration of the advice of the Central Legal Office of the National Services Division and in consultation with the Chief Executive, to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests.

In circumstances where a claim against the Board is settled by a decision of a Court, and the decision is not subject to appeal, the Executive Directors of the Board shall, following consultation with the Chief Executive, implement the decision of the relevant Court on behalf of the Board.

The Executive Directors of the Board acting together with the Heads of Finance must bring to the attention of the Chief Executive and Director of Finance any claim deemed to pose a significant risk to the Board's Revenue Resources.

3.4.4 Procurement of Supplies and Services

The Executive Directors of the Board shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders.

The Executive Directors of the Board, acting together with the Heads of Finance, have authority to approve on behalf of the Board the acceptance of tenders, in respect of the Operational Units submitted in accordance with the Board's Standing Orders, up to a value defined within the Delegated Levels of Authority and within the limits of previously approved Revenue and Capital Budgets.

The Executive Directors of the Board shall work with the designated Finance Officer and the Director of Finance to produce a listing, including specimen signatures, of those officers or agents to whom he has given delegated authority to sign official orders on behalf of the Board and the Operational Units.

3.4.5 Human Resources

The Executive Directors of the Board may appoint staff in accordance with the Board's Standing Orders, Human Resources Policies and Delegated Levels of Authority.

The Executive Directors of the Board may, after consultation and agreement with Human Resources amend staffing establishments in respect of the number and grading of posts. In so doing, the Heads of Finance must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to workforce planning, approved by the Board or the Staff Governance Committee.

The Executive Directors of the Board may attend and may authorise any member of staff to attend within and outwith the United Kingdom conferences, courses or meetings of relevant professional bodies and associations, provided that:

- attendance is relevant to the duties or professional development of such member of staff; and
- appropriate allowance has been made within approved budgets; or
- external reimbursement of costs is to be made to the Board.

The Executive Directors of the Board may, in accordance with the Board's agreed Management of Employee Conduct Policy, take disciplinary action in respect of members of staff, including dismissal where appropriate.

The Executive Directors of the Board may, following consultation and agreement with the appropriate Human Resources Officer and the Heads of Finance and the Remuneration Committee approve payment of honoraria to any employee within the Operational Units.

3.4.6 Patients & Clients' Valuables

The Executive Directors of the Board shall have overall responsibility for ensuring that the Board's Operational Units comply with legislation in respect of patients' and clients' valuables and that effective and efficient management arrangements are in place.

PROVISIONS APPLICABLE TO OPERATIONAL DIRECTORS AND TO CHIEF OFFICERS

3.5.1 General Provisions

Operational Directors and Chief Officers of the Board shall have delegated authority and responsibility from the Board Chief Executive to secure the economical, efficient and effective operation and management of their areas of responsibility and to safeguard their assets:

- in accordance with the current policies and decisions made by the Board;
- within the limits of the resources made available to the Operational Units/Corporate Services by the Board;
- in accordance with the Board's Standing Orders and Standing Financial Instructions; and
- in accordance with the relevant Scheme of Establishment.

Operational Directors and Chief Officers have a general duty to assist the Chief Executive in fulfilling his/her responsibilities as the Accountable Officer of the Board.

Operational Directors and Chief Officers are authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chair or the Vice-Chair of the Board, the Chief Executive and where appropriate the Chair of the relevant Committee. Such measures that might normally be outwith the scope of the authority delegated by the Board or its Standing Committees to the Chief Executive, and consequently to Chief Officers, shall be reported to the Board or appropriate Board Committee as soon as possible thereafter.

Operational Directors and Chief Officers are authorised to give a direction in special circumstances that any officer within their area of responsibility shall not exercise a delegated function, subject to reporting on the terms of the direction to the next meeting of the Board.

3.5.2 Finance

Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by other Directors and Chief Officers, after taking account of the advice of the Director of Finance or their Deputy, for their respective areas. Operational Directors and Chief Officers, acting together with the designated Finance Officer have delegated authority to approve the transfer of funds between budget heads, including transfers from reserves and balances, up to a maximum of £500,000 (in the case of the operational Directors and Chief Officers) or £200,000 (in the case of the Heads of Service) in any one instance. Those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest shall be notifed to the Finance, Resources and Performance Committee.

Chief Officers may, acting together with the Director of Finance, and having taken all reasonable action to pursue recovery, approve the writing-off of losses in their respective Health and Social Care Partnerships to the financial limits and categorisation of losses laid down from time to time by the Scottish Government Health Department.

3.5.3 Legal Matters

Operational Directors and Chief Officers are authorised to institute, defend or appear in any legal proceedings or any inquiry, (including proceedings before any statutory tribunal, board or authority) in respect of their respective service areas and following consideration of the advice of the Central Legal Office of the National Services Scotland and in consultation with the Chief Executive, to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests.

In circumstances where a claim against the Board is settled by a decision of a Court, and the decision is not subject to appeal, operational Directors and Chief Officers shall, following consultation with the Chief Executive, implement the decision of the relevant Court on behalf of the Board.

Operational Directors and Chief Officers acting together with the Deputy Director of Finance must bring to the attention of the Chief Executive and Director of Finance any claim deemed to pose a significant risk to the Board's Revenue Resources.

3.5.4 Procurement of Supplies and Services

Operational Directors and Chief Officers shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders.

Operational Directors and Chief Officers, acting together with the Deputy Director of Finance, have authority to approve on behalf of the Board the acceptance of tenders, in respect of their respective Health and Social Care Partnerships submitted in accordance with the Board's Standing Orders, up to a value defined within the Delegated Levels of Authority and within the limits of previously approved Revenue and Capital Budgets.

Operational Directors and Chief Officers shall work with the designated Finance Officer and the Director of Finance to produce a listing, including specimen signatures, of those officers or agents to whom he has given delegated authority to sign official orders on behalf of the Board within their areas of responsibility.

3.5.5 Human Resources

Operational Directors and Chief Officers may appoint staff in accordance with the Board's Standing Orders, Human Resources Policies and Delegated Levels of Authority.

Operational Directors and Chief Officers may, after consultation and agreement with Human Resources and the relevant Heads of Service amend staffing establishments in respect of the number and grading of posts. In so doing, the Deputy Director of Finance must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit approved for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to workforce planning, approved by the Board or the Staff Governance Committee.

Operational Directors and Chief Officers may attend and may authorise any member of staff to attend within and outwith the United Kingdom conferences, courses or meetings of relevant professional bodies and associations, provided that:

- attendance is relevant to the duties or professional development of such member of staff; and
- appropriate allowance has been made within approved budgets; or
- external reimbursement of costs is to be made to the Board.

Operational Directors and Chief Officers may, in accordance with the Board's agreed Management of Employee Conduct Policy, take disciplinary action in respect of members of staff, including dismissal where appropriate.

Operational Directors and Chief Officers may, following consultation and agreement with the appropriate Senior Human Resources Officer, the Heads of Finance, and the Remuneration Sub Committee, approve payment of honoraria to any employee within the Operational Units.

3.5.6 Patients & Clients' Valuables

Operational Directors and Chief Officers shall have overall responsibility for ensuring compliance with legislation in respect of patients' and clients' valuables and that effective and efficient management arrangements are in place.

APPENDIX A

DELEGATED OPERATIONAL RESPONSIBILITY FOR FUNCTIONS ACROSS HEALTH AND SOCIAL CARE PARTNERSHIP AREAS

1. ARGYLL AND BUTE INTEGRATION JOINT BOARD

NHS Highland has delegated the following range of health services to the Argyll and Bute Integration Joint Board for its local population:-

- Hospital inpatient (scheduled and unscheduled)
- Rural General Hospitals
- Mental Health
- Paediatrics
- Community Hospitals
- Hospital Outpatient Services
- NHS Community Services - Nursing, Allied Health Professionals, Mental Health Teams, Specialist End of Life Care, Homeless Service, Older Adult Community Psychiatric Nursing, Re-ablement, Geriatricians Community/Acute, Learning Disability Specialist, Community Midwifery, Speech and Language Therapy, Occupational Therapy, Physiotherapy, Audiology
- Community Children's Services - Child and Adolescent Mental Health Service, Primary Mental Health workers, Public Health Nursing, Health visiting, School Nursing, Learning Disability Nursing, Child Protection Advisors, Speech and Language Therapy, Occupational Therapy, Physiotherapy and Audiology, Specialist Child Health Doctors and Service Community Paediatricians
- Public Health
- GP Services
- GP Prescribing
- General Dental, Opticians and Community Pharmacy
- Support Services
- Contracts and Service Level agreements with other NHS boards covering adults and children

2. HIGHLAND HEALTH AND SOCIAL CARE PARTNERSHIP

NHS Highland has delegated the following range of health services to the Highland Health and Social Care Partnership:

- accident and emergency
- acute hospital care
- acute mental health
- adult social work teams
- equipment stores
- care at home
- care homes
- community hospitals
- community mental health teams
- community nurses
- day care
- dental services
- district general hospitals handyperson services
- health visitors
- learning disability

- midwifery services
- nutrition and dietetics
- occupational therapy
- pharmacy
- physiotherapy
- podiatry
- primary care services
- respite services
- rural general hospitals
- self-directed support
- speech and language therapy
- tele-care

NHS Highland

SECTION E

FRAUD POLICY AND RESPONSE PLAN

Finance Department

Warning – Document uncontrolled when printed

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Lead Reviewer:	Fraud Champion	**Version:**	1.7
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Distribution:

- Executive Directors
- Non Executive Members
- All Managers
- All Staff

Method
Intranet ✓

Fraud Policy

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2. The Bribery Act 2010 – Key Points
3. The Bribery Act 2010 – NHS Highland's Aims & Objectives
4. National Fraud Initiative
5. Guidance to Staff on Fraud/Bribery/Corruption/Theft
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FRAUD POLICY

1 Introduction

1.1 NHS Highland is committed to maintaining strict ethical standards and integrity in the conduct of its business activities. All NHS Highland staff and individuals acting on NHS Highland's behalf are responsible for conducting NHS Highland's business professionally, with honesty, integrity and maintaining the organisation's reputation and free from bribery.

1.2 One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk of and the means of enforcing the rules against fraud/theft and other illegal acts involving corruption, dishonesty or damage to property.

2 The Bribery Act 2010 – Key Points

2.1 The Bribery Act 2010 ("The Act") came into effect on 1 July 2011, aiming to tackle bribery and corruption in both the private and public sectors.

2.2 The Act is one of the strictest pieces of legislation on bribery and makes it a criminal offence for any individual (employee, contractor, agent) associated with NHS Highland, to give, promise or offer a bribe, and to request, agree to receive or accept a bribe (sections 1, 2 & 6 offences) and this can be punishable for an individual by imprisonment of up to ten years.

2.3 In addition, the Act introduces a corporate offence (section 7 offence) which means that NHS Highland can be exposed to criminal liability, punishable by an unlimited fee, if it fails to prevent bribery by not having adequate preventative procedures in place that are robust, up to date and effective. The corporate offence is not a stand-alone offence and will follow from a bribery/corruption offence committed by an individual associated with NHS Highland, in the course of their work. NHS Highland therefore takes its legal responsibilities very seriously.

2.4 If a bribery offence is proved to have been committed by an outside body corporate with the consent or connivance of a director or senior officer of NHS Highland, under the Act, the director or senior officer would be guilty of an offence (section 14 offence) as well as the body corporate which paid the bribe.

3 The Bribery Act 2010 – NHS Highland's Aims & Objective's

3.1 NHS Highland welcomes the Act and is keen to ensure compliance with the Act's standards.

3.2 NHS Highland does not tolerate any form of bribery, whether direct or indirect, by its staff, agents or external consultants or any persons or entities acting for it or on its behalf.

3.3 NHS Highland will not conduct business with service providers, agents or representatives that do not support its anti-bribery statement and it reserves the right to terminate its contractual arrangements with any third parties acting for or on behalf of NHS Highland with immediate effect, where there is evidence that they have committed acts of bribery.

3.4 The success of NHS Highland's anti-bribery measures depends on all employees, and those acting for NHS Highland, playing their part in helping to detect and eradicate bribery. Therefore, all employees and others acting for or on behalf of NHS Highland are encouraged to report any suspected bribery.

4 National Fraud Initiative (NFI)

4.1 NHS Highland is required by law to protect the public funds it administers. It may share information provided to it with other bodies responsible for auditing or administering public funds, in order to prevent and detect fraud.

5 Guidance to Staff on Fraud/Bribery/Corruption/Theft

5.1 This guidance is not intended solely for staff. It is also intended for anyone acting on the Board's behalf including Non-Executive Directors, the Board's contractors, agents etc. Reference to 'staff' in this section will also mean all of these.

5.2 The Fraud Policy relates to all forms of fraud, bribery, corruption or theft and is intended to provide guidance to employees on the action, which should be taken when any of these are suspected. Such occurrences may involve employees of NHS Highland, suppliers/contractors or any third party. This document sets out the Board's policy and response plan for detected or suspected fraud, bribery, corruption or theft. It is not the purpose of this document to provide direction on the prevention of fraud.

5.3 Whilst the exact definition of fraud, bribery, corruption or theft is a statutory matter, the following working definitions are given for guidance:

- Fraud broadly covers deliberate material misstatement, falsifying records, making or accepting improper payments or acting in a manner not in the best interest of the Board for the purposes of personal gain.
- Bribery is an inducement or reward offered, promised or provided in order to gain any commercial, contractual, regulatory or personal advantage;
- Corruption relates to a lack of integrity or honesty, including the use of trust for dishonest gain. It can be broadly defined as the offering or acceptance of inducements, gifts, favours, payments or benefits in kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly, however they may be unreasonably using their position to give some advantage to another;
- Theft is removing property belonging to NHS Highland, its staff or patients with the intention of permanently depriving the owner of its use, without their consent.

For simplicity this document will refer to all such offences as "fraud", except where the context indicates otherwise.

5.4 NHS Highland already has procedures in place, which reduce the likelihood of fraud occurring. These are included within the Code of Corporate Governance (ie Standards of Business Conduct, Standing Orders, Standing Financial Instructions), financial procedures, systems of internal control and risk assessment. The Board takes part in post payment verification system which covers all Family Health Service expenditure.

5.5 It is the responsibility of NHS Highland and its management to maintain adequate and effective internal controls, which deter and facilitate detection of any fraud. The role of Internal Audit is to evaluate these systems of control. It is not the responsibility of Internal Audit to detect fraud, but rather to identify weaknesses in systems that could potentially give rise to error or fraud.

6 Collaborating to Combat Fraud

6.1 NHS Highland will work closely with other organisations, including Counter Fraud Services, the Central Legal Office, Audit Scotland, the Cabinet Office, Department for Work and Pensions, the Home Office, Councils, the Police and the Procurator Fiscal/Crown Office to combat fraud.

6.2 NHS Highland will agree formal partnership agreements with other investigative bodies e.g. Counter Fraud Services (CFS) and, where appropriate, engage in joint investigations and prosecutions.

6.3 The Cabinet Office on behalf of Audit Scotland assists appointed auditors by conducting a National Fraud Initiative which is a data matching exercise. Data matching involves comparing computer records held by one body against other computer records held by the same or another body. This is usually personal information. Computerised data matching allows potentially fraudulent claims and payments to be identified. Where a match is found it indicates that there may be an inconsistency which requires further investigation. No assumption can be made as to whether there is fraud, error or other explanation until an investigation is carried out. The exercise can also help bodies to ensure that their records are up to date.

6.4 Audit Scotland currently requires NHS Highland to participate in a statutory data matching exercise under its powers in Part 2A of the Public Finance and Accountability (Scotland) Act 2000 to assist in the prevention and detection of fraud. We are required to provide particular sets of data to the Cabinet Office on behalf of Audit Scotland for matching in each exercise, and these are set out in Audit Scotland's instructions for Participants. It does not require the consent of the individuals concerned under the Data Protection Act 2018.

6.5 Data matching in Scotland is subject to a Code of Data Matching Practice, and information on Audit Scotland's legal powers and the reasons why it matches particular information, is provided in the full text Privacy Notice.

7 Public service values

7.1 The expectation of high standards of corporate and personal conduct, based on the recognition that patients come first, has been a requirement throughout the NHS since its inception. MEL (1994) 80, "Corporate Governance in the NHS", issued in August 1994, sets out the following public service values:

Accountability: Everything done by those who work in the organisation must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity: Absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers and customers.

Openness: The organisation's activities should be sufficiently public and transparent to promote confidence between the organisation and its patients, staff and the public.

7.2 All those who work in the organisation should be aware of, and act in accordance with, the above values. In addition, NHS Highland will expect and encourage a culture of openness between NHS bodies and the sharing of information in relation to any fraud.

8 NHS Highland policy & public interest disclosure act

8.1 NHS Highland is committed to maintaining an honest, open and well-intentioned atmosphere within the service. It is committed to the deterrence, detection and investigation of any fraud within NHS Highland.

8.2 NHS Highland encourages anyone having reasonable suspicion of fraud to report the incident. It is NHS Highland's policy that no staff member will suffer in any way as a result of reporting any reasonably held suspicions. For these purposes "reasonably held suspicions" shall mean any suspicions other than those which are groundless and/or raised maliciously.

8.3 In addition, the Public Interest Disclosure Act protects workers who legitimately report wrongdoing by employers or colleagues. The disclosure must be made in good faith and workers must have reasonable grounds to believe that criminal offences such as fraud or theft have occurred or are likely to occur. The disclosure must not be made for personal gain.

9 Instructions to staff

9.1 Staff who suspect improper practices or criminal offences are occurring relating to fraud, theft, bribery or corruption, should normally report these to the Fraud Liaison Officer (FLO) via their line manager, but may report directly where the line manager or Head of Department is unavailable or where this would delay reporting. If the suspected improper practice involves the Head of Department, the report should be made to a more senior officer or the nominated officer as described in 13.1 below. Managers receiving notice of such offences must report them to the nominated officer.

9.2 It should be noted that staff who wish to raise concerns about unprofessional behaviour or decisions, where fraud, theft, bribery or corruption are not suspected, should do so by following the guidance contained in the NHS Highland's Whistleblowing Policy. Following investigation of the complaint, if improper practices or criminal offences are suspected, the matter should be referred by the investigating officer, to the FLO. Any further action taken will follow the guidance contained within this policy.

9.3 Confidentiality must be maintained relating to the source of such reports.

9.4 Further choices for staff are:

You may use the Counter Fraud Service (CFS) Fraud Hot Line which is 0800 151628 or report your suspicions (anonymously, if desired) through the CFS Website on www.cfs.scot.nhs.uk

9.5 It should be added that under no circumstances should a member of staff speak or write to representatives of the press, TV, radio, other third parties or use blogs or twitter to publicise details about a suspected fraud/theft. Care needs to be taken that nothing is done which could give rise to an action for slander or libel.

9.6 Please be aware that time may be of the utmost importance to ensure that NHS Highland does not continue to suffer a loss.

10 Roles & responsibilities

10.1 Responsibility for receiving information relating to suspected frauds and for co-ordinating NHS Highland's response to the NFI exercises has been delegated to the FLO. This individual is responsible for informing third parties such as CFS, the Cabinet Office on behalf of Audit Scotland, Internal and External Audit or the Police when appropriate. The FLO shall inform and consult the Chief Executive, Director of Finance, the Board Chairman and the Chairman of the Audit Committee in cases where the loss may be above the delegated limit or where the incident may lead to adverse publicity. The contact name and address of the FLO, is as follows:

Barbara Milne
Technical Accountant
Assynt House
Beechwood Park
Inverness IV2 3BW

01463 704609
E mail: barbara.milne1@nhs.net

10.2 Where a fraud is suspected within the service, including the Family Health Services i.e. independent contractors providing Medical, Dental, Ophthalmic or Pharmaceutical Services, the FLO will make an initial assessment and, where appropriate, advise CFS at the NHS National Services Scotland.

10.3 The Director of Human Resources or nominated deputy, shall advise those involved in the investigation on matters of employment law and other procedural matters, such as disciplinary and complaints procedures.

10.4 Where the incident is thought to be subject to either local or national controversy and publicity then the Board and the Scottish Government Health Directorates should be notified before the information is subjected to publicity.

10.5 It is the responsibility of NHS Highland's senior officers to ensure that their staff are aware of the above requirements and that appropriate reporting arrangements are implemented.

10.6 It is the responsibility of all staff to protect the assets of NHS Highland. Assets include information and goodwill as well as property.

10.7 It shall be necessary to categorise the irregularity prior to determining the appropriate course of action. Two main categories exist:

- Theft (except theft by fraud), burglary and isolated opportunist offences; and
- Fraud, bribery, corruption and other financial irregularities.

The former will be dealt with directly by the Police whilst the latter may require disclosure under the SGHSCD NHS Circular No. CEL (2013)11 – Strategy to Combat Financial Crime in NHS Scotland.

10.8 Responsibility for ensuring that recommendations from CFS investigation reports and from data matching exercises conducted under NFI have been implemented and steps taken to ensure full compliance has been delegated to the CFC, name and address below.

11 Contact Points

Relevant contact points are as follows:

Counter Fraud Champion:	Alasdair Christie Non Executive Director Assynt House, Beechwood Park Inverness IV2 3BW
Fraud Liaison Officer:	Barbara Milne Assynt House, Beechwood Park Inverness IV2 3BW 01463 704609 E mail: barbara.milne1@nhs.net
Deputy Fraud Liaison Officer:	Jacqui Fraser Assynt House, Beechwood Park Inverness IV2 3BW 01463 704884 Email: jacqui.fraser1@nhs.net
Director of Finance:	David Garden Assynt House, Beechwood Park Inverness IV2 3BW 01463 704924 Email: david.garden@nhs.net
Board Secretary:	Ruth Daly Assynt House, Beechwood Park Inverness IV2 3BW 01463 704868 Email: ruth.daly@nhs.net
Accountable Officer for Controlled Drugs:	Ian Rudd Assynt House, Beechwood Park Inverness IV2 3BW 01463 706895 Email: ian.rudd@nhs.net
Head of Community Pharmacy Services and CD Governance:	Jackie Agnew Assynt House, Beechwood Park Inverness IV2 3BW 01463 706830

	Email: jackie.agnew@nhs.net
Head of Specialist Pharmaceutical Services:	Rhona Gunn (on leave 01/09/18 – 31/08/19) Susan Caldwell (covering above Raigmore Hospital Inverness 01433 705582 Email: rhona.gunn@nhs.net Email: susan.calwell1@nhs.net
Medicines Management Development Nurse:	Ruth Miller Assynt House Inverness 01433 705168 Email: ruth.miller@nhs.net
Lead Pharmacist: (North & West)	Findlay Hickey Larachan House 9 Dochcarty Road Dingwall 01349 869229 Email: findlay.hickey@nhs.net
Lead Pharmacist: (South & Mid)	Thomas Ross Assynt House Beechwood Park Inverness IV2 3BW 01463 706980 Email: thomas.ross@nhs.net
Lead Pharmacist: (Mental Health)	Karen MacAskill New Craigs Hospital Leachkin Road Inverness 01463 704663 Email: karen.macaskill@nhs.net
Lead Pharmacist: Argyll & Bute	Fiona Thomson Lorn & Islands Hospital Glengallan Road Oban PA34 4HH 01631 788942 Email: fiona.thomson5@nhs.net
Internal Auditor:	Scott Moncrieff Tel: 0131 473 3500

Counter Fraud Services: www.cfs.scot.nhs.uk
National Fraud Initiative: www.audit-scotland.gov.uk/work/nfi.pho

RESPONSE PLAN

12 Introduction

The following sections describe NHS Highland's intended response to a reported suspicion of fraud/bribery/corruption or theft. It is intended to provide procedures, which allow for evidence gathering and collation in a manner that will facilitate informed initial decision, while ensuring that evidence gathered will be admissible in any future criminal or civil action. Each situation is different; therefore the guidance will need to be considered carefully in relation to the actual circumstances of each case before action is taken.

13 Reporting fraud

13.1 A "nominated officer" will be appointed as the main point of contact for the reporting of any suspicion of fraud, corruption, bribery or theft. For NHS Highland, this officer is the FLO (see 9.1). In the absence of the FLO, the Deputy will deal with the issue. For incidents involving any Executive Directors, the nominated officer shall be the Board's Chairman, contacted through the FLO.

13.2 The FLO shall be trained in the handling of concerns raised by staff. Any requests for anonymity shall be accepted and should not prejudice the investigation of any allegations. Confidentiality should be observed at all times.

13.3 All reported suspicions must be investigated as a matter of priority to prevent any further potential loss to NHS Highland.

13.4 The FLO shall maintain a log of any reported suspicions. The log will document with reasons the decision to take further action or to take no further action. The log will also record any actions taken and conclusions reached. This log will be maintained and will be made available for review by Internal Audit.

13.5 The FLO should consider the need to inform the Highland NHS Board, the Chief Internal Auditor, External Audit, the Police and CFS, of the reported incident. In doing so, they should take cognisance of the following guidance:

- inform and consult the Director of Finance and the Chief Executive at the first opportunity, in all cases where the loss may exceed the delegated limit (or such lower limit as NHS Highland may determine) or where the incident may lead to adverse publicity;
- it is the duty of the Director of Finance to notify the Chief Executive and Chairman immediately of all losses where fraud/theft is suspected.
- CFS should normally be informed immediately in all but the most trivial cases.
- If fraud, bribery or corruption is suspected, it is essential that there is the earliest possible consultation with CFS. In any event, CFS should be contacted before any overt action is taken which may alert suspects and precipitate the destruction or removal of evidence. This includes taking action to stop a loss or tighten controls.
- at the stage of contacting the Police, the FLO should contact the Director of Human Resources to consider whether/when to initiate suspension of the employee pending an enquiry.

13.6 All such contact should be formally recorded in the Log.

14 Managing the investigation

14.1 The Director of Finance will appoint a manager to oversee the investigation. Normally, the manager will be an employee from CFS. The circumstances of each case will dictate who will be involved and when.

14.2 The manager overseeing the investigation (referred to hereafter as the "investigation manager") should initially:

- initiate a Diary of Events to record the progress of the investigation;
- if possible, determine the nature of the investigation i.e. whether fraud or another criminal offence. In practice it may not be obvious if a criminal event is believed to have occurred. If this is established the Police, External Audit and the Chief Executive should be informed if this has not already been done.

14.3 If after initial CFS enquiries it is determined that there are to be no criminal proceedings then a NHS Highland internal investigation may be more appropriate. In this instance, all information/evidence gathered by CFS will be passed to NHS Highland. The internal investigation will then be taken forward in line with Employment law, PIN guidelines and relevant Workforce policies such as the Management of Employee Conduct, as appropriate.

14.4 The formal internal investigation to determine and report upon the facts, should establish:

- the extent and scope of any potential loss;
- if any disciplinary action is needed;
- the criminal or non-criminal nature of the offence, if not yet established;
- what can be done to recover losses; and
- what may need to be done to improve internal controls to prevent recurrence.

14.5 This report will normally take the form of a report to NHS Highland's Audit Committee.

14.6 Where the report confirms a criminal act and notification to the Police has not yet been made, it should now be made.

14.7 Where recovery of a loss to NHS Highland is likely to require a civil action, arising from any act (criminal or non-criminal), it will be necessary to seek legal advice through the Central Legal Office, which provides legal advice and services to NHS Scotland.

14.8 This report should form the basis of any internal disciplinary action taken. The conduct of internal disciplinary action will be assigned to the Director of Human Resources or delegated officer within the Directorate, who shall gather such evidence as necessary.

15 Disciplinary/dismissal procedures

15.1 Consideration should be made in conjunction with CFS/FLO on whether/when to suspend the employee(s) who are subject to any investigation, pending the results of the investigation. This should be carried out in line with NHS Highland's Employee Conduct Policy.

15.2 The disciplinary procedures of NHS Highland have to be followed in any disciplinary action taken by NHS Highland toward an employee (including dismissal). This may involve the investigation manager recommending a disciplinary hearing to consider the facts, consideration of the results of the investigation and making further recommendations on appropriate action to the employee's line manager

Where the fraud involves a Family Health Services Practitioner, the Board should pass the matter over to the relevant professional body for action.

16 Gathering evidence

16.1 This policy cannot cover all the complexities of gathering evidence. Each case must be treated according to the circumstances of the case taking professional advice as necessary.

16.2 If a witness to the event is prepared to give a written statement, it is best practice for an experienced member of staff, preferably from the Human Resources Directorate, to take a chronological record using the witness's own words. The witness should sign the statement only if satisfied that it is a true record of their own words.

16.3 At all stages of the investigation, any discussions or interviews should be documented and where feasible agreed with the interviewee.

16.4 Physical evidence should be identified and gathered together (impounded) in a secure place at the earliest opportunity. An inventory should be drawn up by the investigating officer and held with the evidence. Wherever possible, replacement or new document etc. should be put into use to prevent access to the evidence. If evidence consists of several items, for example a number of documents, each one should be tagged with a reference number corresponding to the written record.

16.5 CFS staff acting on behalf of the Director of Finance require and are to receive access to;

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

17 Interview procedures

17.1 Interviews with suspects should be avoided until the formal disciplinary hearing. The investigating officer should, wherever possible, gather documentary and third party evidence for the purposes of their report. If, however, an employee insists on making a statement it must be signed and dated and should include the following:

"I make this statement of my own free will; I understand that I need not say anything unless I wish to do so and that what I say may be given in evidence".

17.2 Informal contact with the Police should be made at an early stage in the investigation to ensure that no actions are taken which could prejudice any future criminal case through the admissibility of evidence, etc.

18 Disclosure of loss from fraud

18.1 Guidance on the referring of losses and special payments is provided in CEL10 (2010). External Audit should be notified of any loss as part of their statutory duties. Scottish Financial Return (SFR) 18.0 on Losses and Compensation Payments is submitted annually to the Audit Committee and will include all losses with appropriate description within the standard categories specified by the SGHSCD.

18.2 Management must take account of the permitted limits on writing off losses for "Category 2 Boards", as outlined in circular CEL (2010).

19 Police Involvement

19.1 It shall normally be the policy of NHS Highland that, wherever a criminal act of theft (except theft by fraud), burglary and isolated opportunist offences; is suspected, the matter will be notified **to the Police, as** follows:

- During normal working hours, it will be the decision of the Director of Finance as to the stage that the Police are contacted. If the Director of Finance is unavailable, this decision will be delegated to the FLO;
- Out with normal working hours, the manager on duty in the area where a criminal act is suspected, may contact the Police and is duty bound to report the matter to the Director of Finance at the earliest possible time.

19.2 The FLO and investigating manager should informally notify the Police of potential criminal acts, to seek advice on the handling of each investigation at an early stage in the investigation.

19.3 Formal notification of a suspected criminal act will normally follow completion of the investigating manager's report and formal disciplinary action. It is important that the internal report is carried out in a timely manner to avoid delaying the Police investigation.

20 Press Release

20.1 To avoid potentially damaging publicity to the NHS and/or the suspect, NHS Highland should prepare at an early stage, a Press release, giving the facts of any suspected occurrence and any actions taken to date e.g. suspension. CFS, the Central Legal Office and the Police should agree the release where applicable.

21 Resourcing the investigation

21.1 The Director of Finance will determine the type and level of resource to be used in investigating suspected fraud. The choices available will include:

- Internal staff from within NHS Highland
- Human Resources
- Internal Audit
- External Audit
- CFS
- Specialist Consultant
- Police

21.2 In making a decision, the Director Finance, should consider independence, knowledge of the organisation, cost, availability and the need for a speedy investigation. Any decision must be shown in the Log held by the FLO. A decision to take "No action" will not normally be an acceptable option unless exceptional circumstances apply.

21.3 In any case involving a suspected criminal act, it is anticipated that CFS involvement will be in addition to NHS Highland resources. In any case involving other suspected criminal acts, it is anticipated that Police involvement will be in addition to NHS Highland resources.

22 The law and its remedies

22.1 Criminal Law

The Board shall refer all incidences of suspected fraud/criminal acts to Counter Fraud Services or the Police for decision by the Procurator Fiscal as to any prosecution.

22.2 Civil Law

The Board shall refer all incidences of loss through proven fraud/criminal act to the Central Legal Office for opinion, as to potential recovery of loss via Civil Law action.

Annex 1 to this policy gives guidance to staff on the action which should be taken in all cases where misappropriation of medicines is suspected.

Annex 1

SAFE AND SECURE HANDLING OF MEDICINES

Suspected or actual theft of medicines

Theft of medicines is a serious criminal offence under the Medicines Act 1968, the Misuse of Drugs Act 1971 and other legislation and will be dealt with accordingly by NHS Highland, professional regulatory bodies and the police.

1.1 Any member of staff who has reason to believe that medicines have been taken without authority has a duty to report their concerns to the Nurse in Charge of the clinical area/ Line Manager.

1.2 All concerns will be treated in the strictest confidence subject to procedural requirements associated with any formal escalation. All investigations must be carried out in a discreet manner.

1.3 The Nurse in Charge/ Line Manager must take reasonable steps to ensure that medicines are in fact missing, for example check administration records; cupboards not normally used for storage of medicines and pharmacy delivery records. Any evidence must be retained pending further investigation.

1.4 If the Nurse in Charge/ Line Manager is unable to satisfy him or herself that all medicines can be accounted for, they must report their suspicions to the Senior Clinical Pharmacist and the relevant Service Manager (or Duty Manager out of hours) at the earliest opportunity. If immediate action is required (e.g. witnessed theft or where key evidence may otherwise be lost) the police must be contacted.

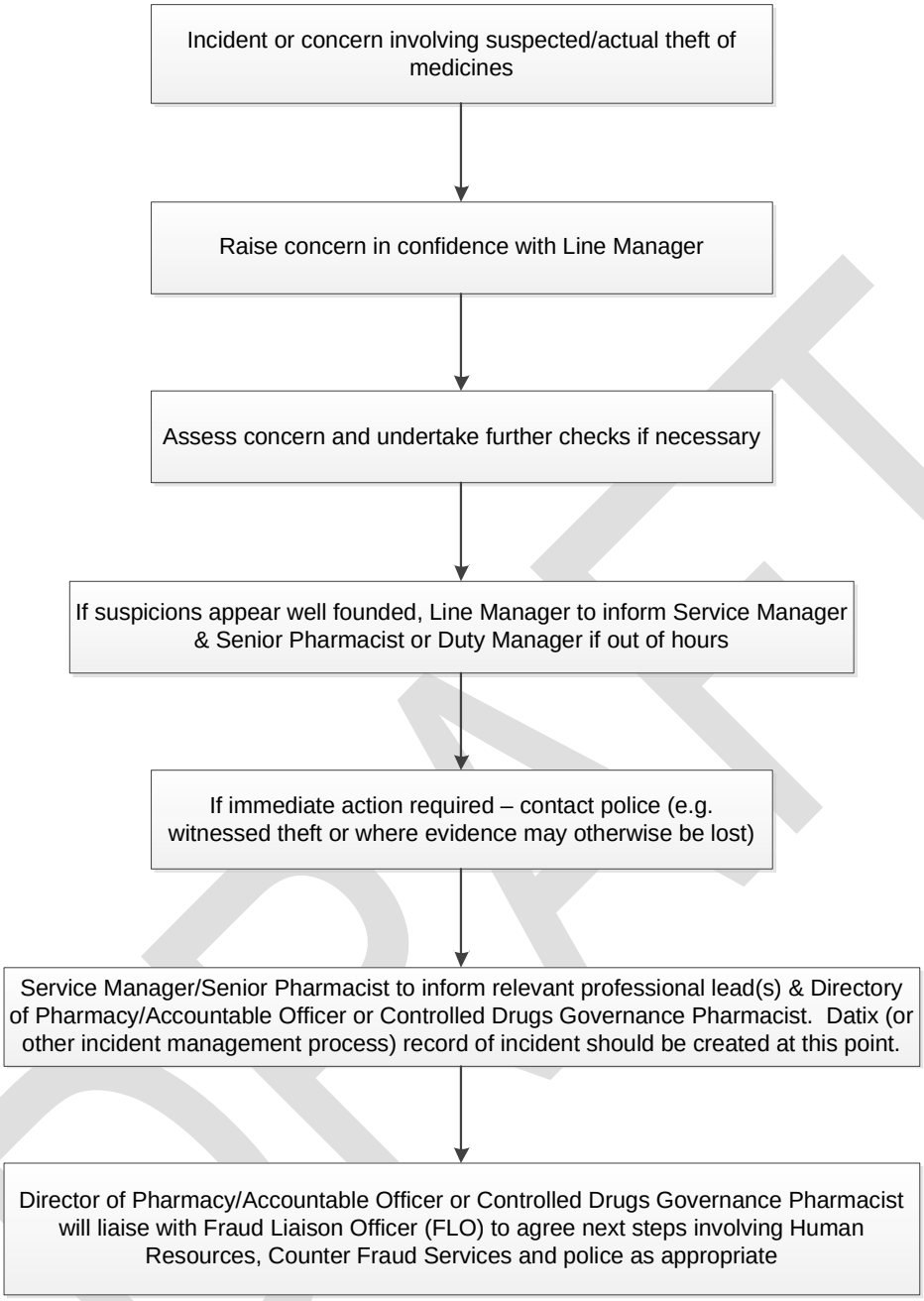
1.5 Where a Service Manager/Senior Clinical Pharmacist has been informed of suspected/ actual theft of medicines, they must inform the relevant professional lead(s) and the Head of Pharmacy/Accountable Officer for CDs who will liaise with the FLO and agree a course of action commensurate with the circumstances presented, which may include referring the matter to CFS or the Police.

1.6 The flowchart which follows this page must be followed in all cases of suspected/actual theft of medicines.

1.7 Note that the Incident Management Policy for Significant Events must also be followed in the event of any such incident. link here

SUSPECTED OR ACTUAL THEFT OF MEDICINES - FLOWCHART

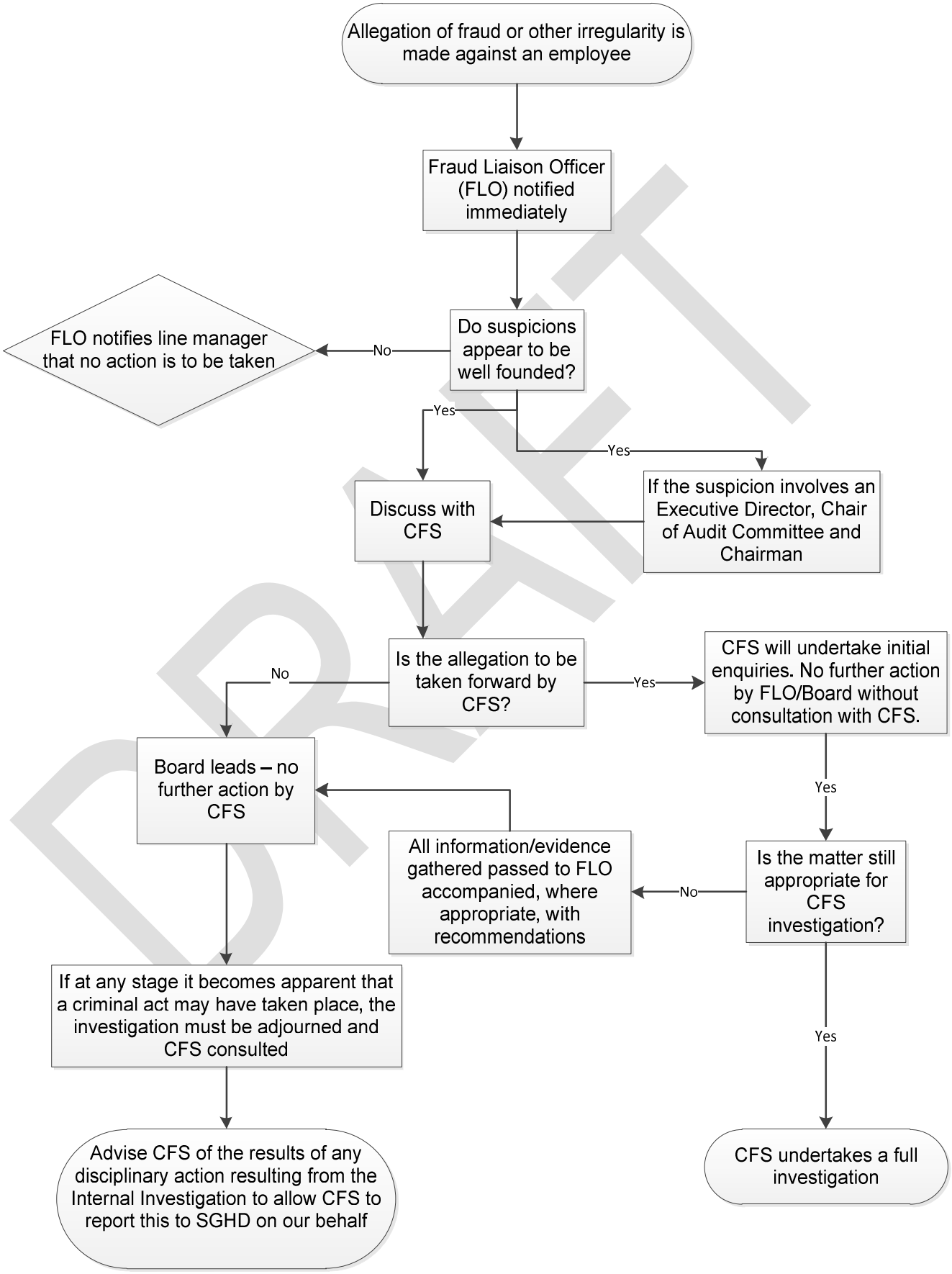
Annex 2



Note: All actions must be undertaken as discreetly as possible and in confidence

PROCEDURES FOR DEALING WITH ALLEGATIONS FRAUD/OTHER IREGULARITIES

ANNEX 3



NHS Highland

SECTION F

Standing Financial Procedure for Standards of Business Conduct for NHS Staff

Finance Department

Warning – Document uncontrolled when printed

Policy Reference: Fin 19.0	**Date of Issue:** August 2016
Prepared by:	**Date of Review**: August 2018
Lead Reviewer: Technical Accountant	**Version:** 1.2
Authorised by: Director of Finance	**Date:** August 2016
Planning For Fairness: No	**RIA Completed:** N/A

Distribution

- **Executive Directors**
- **Non Executive Members**
- **All Managers**
- **All Staff**

Method

Intranet □ √

NHS Highland

INDEX

1. Introduction

1.1 The following Standing Financial Procedure (SFP) is for operational use by those members of staff engaged in dealing with Board Suppliers and Contractors as authorised by the Chief Executive. The procedures contained herein are subject to compliance with the NHS Circular MEL (1994) 48.

1.2 The purpose of this SFP is to ensure that all staff are aware of the procedures relating to Standards of Business Conduct for Staff and to protect them from situations where they may be placed in a real or apparent conflict of interest.

1.3 All references to staff in this procedure include both employees and non-executive directors of Highland Health Board. All Health Professionals, including independent contractors and locum practitioners working under the Board's terms and conditions, are included.

1.4 This SFP applies equally to exchequer and charitable sources of funding.

1.5 All Board staff who commit NHS resources directly (e.g. by the ordering of goods) or indirectly (e.g. by the prescribing of medicines) must be impartial and honest in their conduct of business and all employees must remain above suspicion. It is an offence under the Bribery Act 2010 for any employee to request, agree to receive or accept a bribe in return for improperly performing a function or activity. Staff need to be aware that a breach of the provisions of this Act renders them liable to prosecution and may also lead to potential disciplinary action and loss of their employment and superannuation rights in the NHS.

1.6 MEL (1994) 48 details the principles for codes of conduct and accountability in situations where there is potential conflict between the private interests of NHS staff and their NHS duties and requires the establishment of a local code of conduct. This Code reflects the minimum Standards of Business Conduct expected from all NHS staff. Any breaches of the Code may lead to disciplinary action.

1.7 There are three crucial public service values which underpin the work of the Health Service:

1.7.1 Conduct:

There should be an absolute standard of honesty and integrity which should be a hallmark of all personal conduct in decisions affecting patients, staff and suppliers; in the use of information acquired in the course of NHS duties; in dealing with the assets of the NHS.

1.7.2 Accountability:

Everything done by those who work in the NHS must be able to stand the test of parliamentary and public scrutiny, judgements on propriety and professional codes of conduct.

1.7.3 Openness:

NHS Highland should be open about its activities and plans so as to promote confidence between the component parts of the Board, other health organisations and its staff, patients and the public.

1.8 Guidance has been included for the main situations which may arise. Any additional situations which arise should be deferred until advice has been sought from the Director of Finance.

1.9 The SFP will act as an instruction manual and a point of reference and any amendments will be made on the authority of the Chief Executive.

1.10 The SFP has been written with a view to ensuring that procedures are adhered to at all times, especially in cases of hospitality, gifts, etc.

2. Principles of Conduct

2.1 The following principles are designed to protect individuals and the Board:

2.1.1 Employees are expected to:

2.1.1.1 ensure that the interests of patients remain paramount at all times;

2.1.1.2 be impartial and honest in the conduct of their official business;

2.1.1.3 use the public funds entrusted to them to the best advantage of the service, always ensuring value for money; and

2.1.1.4 demonstrate appropriate ethical standards of personal conduct.

2.1.2 It is the responsibility of staff to ensure that they do not:

2.1.2.1 abuse their official position for the personal gain or to the benefit of their family or friends;

2.1.2.2 undertake outside employment that could compromise their NHS duties;

2.1.2.3 seek to advantage or further their private business or interest in the course of their official duties.

2.1.3 Staff must protect themselves and the Board from any allegations of impropriety by seeking advice from their line manager whenever there is any doubt as to the interpretation of this procedure.

3. Procedures

3.1 <u>Action for Managers</u>

3.1.1 Managers must adhere to this guidance and ensure that their staff are aware of and comply with this procedure. To achieve this, each manager should record their receipt and understanding of the SFP, together with evidence that all their staff have been informed of its contents. All staff should be asked to confirm their understanding of the procedure and formally record any interests, outside employment, etc, during their annual appraisal.

3.1.2 Contract Awards:

Favouritism should not be shown in awarding contracts and managers should ensure when they are preparing a tender that a warning against corruption in all invitations to tender is made.

3.1.3 Where an interest, hospitality or relevant outside employment is declared to a manager, they must record that declaration in the employee's personal file, together with any instructions issued to the member of staff in relation to the declaration. All declarations of interests should be notified to the Chief Executive's Office for entry in the central register of Hospitality and Interests for Staff. Any gifts or hospitality which are unusual or likely to arouse controversy should be notified to the Board Secretary and to the Director of Finance.

3.1.4 Managers should consider whether outside employment declared by employees is likely to conflict with their NHS work or be detrimental to it. Generally, directorship of or work with an identified NHS supplier or business competing with the NHS is likely to be unacceptable.

3.1.5 If a manager is informed of a potential conflict of interest, hospitality or outside employment which has not been declared, then he or she should inform the Director of Finance in accordance with the Board's SFP "Fraud Policy and Response Plan".

3.2 Private Practice

3.2.1 Private practice for medical staff is subject to the conditions outlined in the handbook on the management of private practice in health service hospitals (NHS Circular 1987 (GEN) 25) and consultants are subject to the terms detailed therein. Other staff may undertake private practice or work for outside agencies provided they do not do so within time they are contracted to the NHS and they observe the conditions detailed in this SFP.

3.2.2 Doctors in training grades should not undertake locum work outside their contract where such work would be in breach of their contracted hours as set out in the terms and conditions of service and hours control for training grades.

3.3 Intellectual Property Rights

NHS employers are entitled to receive any royalties, rewards or benefits in respect of work commissioned or carried out by their employees in the course of their NHS duties (e.g. software programs). The Patents Act 1997 also gives employees a right to obtain some reward for their efforts and managers should seek advice from the Personnel Team in relevant circumstances.

3.4 Commercial Sponsorship

3.4.1 Financial assistance is often made available by commercial organisations as part of education programmes. This can include sponsorship of meetings at hospitals or provision of financial help towards the attendance at courses and conferences.

3.4.1.1 Provided such events/visits are clearly and primarily for educational purposes of a professional, scientific of technical nature and that funding is limited to reasonable and appropriate expenses only, then such assistance is acceptable.

3.4.1.2 To protect the individual and the Board, details of any event/course where financial assistance or hospitality is offered will be maintained separately and the "**Supplementary Application for Study Leave Hospitality**" form should be completed and attached to the normal Course/Conference Application Request and be approved by the appropriate Executive Director. All applications will be registered with the Board Secretary and available for public inspection.

3.4.2 On occasions when it is considered necessary for staff advising on the purchasing of equipment to expect to see such equipment in operation in other parts of the country (or exceptionally overseas) NHS Highland will meet the cost to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

3.4.2.1 The Board encourages the exchange of information between staff in the NHS, including the sharing of information about products and equipment supplied to NHS hospitals. Visits to other hospitals in the UK for this purpose are, therefore, subject only to the normal Head of Department approval arrangements which would include consideration of the cost of travel/accommodation being met by the Board against the benefit to be gained.

3.4.2.2 The procedures and approvals to be applied where a supplier or manufacturer is involved in such a visit are much more stringent. This is to ensure that staff do not inadvertently breach EC procurement regulations or leave themselves or the Board open to criticism that procedures were not fair and impartial. In this instance, the procedure to be followed will be:-

3.4.2.2.1 Visits to hospitals by suppliers/manufacturers to discuss supplies/equipment are not affected, nor is the supply of literature about current product/ equipment ranges and prices.

3.4.2.2.2 During the process of awarding a contract or purchasing an item of equipment, staff should not undertake visits to factories or other hospital sites under the auspices of a manufacturer/supplier, before the contract/equipment specification has been drawn up and issued.

3.4.2.2.3 As part of the evaluation procedure, it is permissible to visit "demonstration" sites identified by suppliers/manufacturers, provided that all firms invited to tender have an equal opportunity to arrange such visits. In these circumstances, staff should complete the "**Supplementary Application for Study Leave**" form (add link) and obtain the authority of the Chief Executive before participating in such visits. In such

instances, the Chief Executive will consider the question of whether the Board will meet all costs of such visits or whether it is acceptable in the particular circumstances to accept an offer of financial assistance from the supplier/manufacturer.

3.4.3 Companies may offer to sponsor wholly or partially a post. Such an arrangement must not be entered into unless it is made abundantly clear to the company concerned that sponsorship will have no effect on the purchasing decision within NHS Highland. Where sponsorship is accepted, the Director of Finance must be fully involved and will be responsible for the establishment of monitoring arrangements to ensure that purchasing decisions are not being influenced by the sponsorship agreement.

3.4.4 Under no circumstances should any employee agree to linked deals where sponsorship is linked to the purchase of a particular product or to supply from particular sources.

3.4.5 The authorising officer will document all activity, actions or arrangements made under this section and will ensure the central register of Hospitality and Interests of Staff is amended.

3.5 Commercial - In Confidence Information

Managers should take care in using or making public internal information of a "Commercial – in confidence" nature, particularly if its disclosure would prejudice the principle of the purchasing system based on fair competition. This principle applies whether private competitors or other NHS providers are concerned but does not include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit the free exchange of data for clinical audit purposes, for example, subject to the normal rules governing patient confidentiality and data protection. Similarly, if information is requested under the Freedom of Information (Scotland) Act, advice should be sought from the Board Secretary. In all circumstances the overriding consideration must be the best interests of the patients.

3.6 Casual Gifts and Hospitality

3.6.1 Gifts, which could place an individual in a position of conflict between their private interests and that required in the execution of their NHS duties, should be politely but firmly declined. MEL (1994) 48 provides that staff may accept gifts of low intrinsic value or small tokens of gratitude (such as diaries or calendars). On no account should gifts of alcohol be accepted. If in doubt, staff must contact their line manager before acceptance.

3.6.2 Staff may accept modest hospitality, provided that it is normal and reasonable in the circumstances, e.g. lunches in the course of working visits, may be acceptable, though the scale of hospitality should be similar to that which NHS Highland would be likely to offer through the catering department. Staff should decline all other offers of hospitality. If in doubt, staff should seek advice from their line manager. All hospitality accepted by NHS employees must be declared to their line manager who will keep an appropriate record of events and notify the Board Secretary.

3.7 Outside Interests and Employment

3.7.1 Outside interests include directorships, ownership, part-ownership or material shareholdings in companies, business or consultancies likely to seek to do business with NHS Highland. These should be declared to the individual's line manager, as should the interests of a spouse/partner or close relative, who should then inform the Board Secretary.

3.7.2 A conflict of interest may arise as a result of an employee accepting an outside post e.g. with a company that does business or is in competition with NHS Highland. Where there is any doubt, the employee must seek advice from their manager before accepting any outside post.

3.8 Remedies

Managers or staff who fail to comply with the guidance detailed in this SFP could be subject, following full investigation, to disciplinary action up to and including dismissal. If, through their actions or omissions, managers or staff are found to be in contravention of either this guidance or their legal responsibilities, NHS Highland reserves the right to take legal action, if necessary. Where staff suspect, or are aware of non-compliance with this code, they should report any such instances to their line manager, their local Personnel Team contact or the Director of Finance.

3.9 Guidance for Staff

The following guidelines apply to all staff who are in contact with suppliers and contractors, in particular those who are authorised to sign requisitions or orders, or who are expected to advise on the placing of contracts or orders.

3.9.1 Staff should:

3.9.1.1 make sure that they understand the details of this policy and consult their line manager if they are unsure;

3.9.1.2 ensure they are not in a position where private interest and NHS duties conflict;

3.9.1.3 declare to their Head of Department any personal interest which might affect their impartiality, e.g. a direct financial interest in a firm concerned either personally or through a close relative or where a close relative is employed by a potential supplier / contractor;

3.9.1.4 seek permission from their Head of Department before taking on outside work if there is a conflict of interest;

3.9.1.5 obtain permission from their Head of Department before accepting commercial sponsorship.

3.9.2 Staff should not:

3.9.2.1 accept any gifts, inducements or inappropriate hospitality which will place the individual in a position of conflict between their private interest and that required of their NHS duties;

3.9.2.2 abuse past or present official position to obtain preferential rates for private deals;

3.9.2.3 unfairly advantage one competitor over another or show favouritism in awarding contracts;

3.9.2.4 misuse or make available official "commercial – in confidence" information.

3.9.3 Any suspected abuse of this procedure would be subject to investigation under the terms of NHS Highland's Management of Employee Conduct policy.

3.10 Register of Hospitality and interests for Staff other than Board Members

A central register of Hospitality and Interests for staff other than Board Members will be held by the Board Secretary. At least annually, an officer appointed by the Director of Finance will review the register, confirm a sample of entries to available supporting information and report accordingly to the Chief Executive.

3.11 Circulation

Each manager within NHS Highland will receive a copy of this SFP and will confirm their receipt and understanding of the procedure in writing as well as confirming that they have a permanent record of formally informing their staff. All new staff will be made aware of this SFP and its implications for them at induction.

HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE WORKPLAN

Highland Health and Social Care Committee Planner to 31 March 2021

Standing Items for every HHSC Committee meeting

- Apologies
- Declarations of interest
- Minutes of last meeting
- Date of next meeting

HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE WORKPLAN	
OCTOBER	
•	
•	
•	
DECEMBER	
• Community Activity – Resourcing Support for Community Partnerships	**Cathy Steer**
•	
•	
•	
JANUARY 2021	
•	