

There will be a meeting of the **Forth Valley NHS Board** via **MSTeams** on **Tuesday 29 March 2022** at **10.30am**

Janie McCusker
Chair

AGENDA

1. **Apologies for Absence**
2. **Declaration (s) of Interest (s)**
3. **[Minute of Forth Valley NHS Board meeting held on 25 January 2021](#)** Seek Approval
4. **Matters Arising from the Minute** Items 1 to 4
5 minutes
5. **Patient/Staff Story** 15 minutes
[Fiona's Story – The Wedding](#)
6. **FOR APPROVAL**

 - 6.1 **[Financial Plan 2022/23 to 2026/27](#)** Seek Approval
15 minutes
(Paper presented by Mr Scott Urquhart, Director of Finance)
 - 6.2 **Corporate Objectives** Seek Approval
10 minutes
(Presentation led by Mrs Cathie Cowan, Chief Executive)
 - 6.3 **[Code of Corporate Governance](#)** Seek Approval
10 minutes
(Paper presented by Mrs Cathie Cowan, Chief Executive)
 - 6.4 **[Draft Strategic Risk Register Q3 Report](#)** Seek Approval
10 minutes
(Paper presented by Mr Scott Urquhart, Director of Finance)
7. **BETTER CARE**

 - 7.1 **[Pandemic Update](#)** Seek Assurance
10 minutes
(Paper presented by Dr Graham Foster, Director of Public Health)
 - 7.2 **[Healthcare Associated Infection Reporting Template](#)** Seek Assurance
10 minutes
(Paper presented by Prof Angela Wallace, Executive Nurse Director)
 - 7.3 **[Recovery & Performance Scorecard](#)** Seek Assurance
10 minutes
(Paper presented by Mrs Cathie Cowan, Chief Executive)
 - 7.4 **[Whistleblowing Standards](#)** Seek Assurance
15 minutes
(Paper presented by Prof Angela Wallace, Executive Nurse Director)

8. BETTER VALUE

- 8.1 [Finance Report](#) Seek Assurance
(Paper presented by Mr Scott Urquhart, Director of Finance) 10 minutes

9. BETTER GOVERNANCE

- 9.1 [Communications Update](#) Seek Assurance
(Paper presented by Mrs Elsbeth Campbell, Head of Communications) 10 minutes
- 9.2 [Governance Committee Minutes](#) Seek Assurance
15 minutes
- 9.2.1 [Performance & Resources Committee Update: 01/3/2022](#)
[Performance & Resources Committee Minute: 18/01/2022](#)
(Papers presented by Mr John Ford, Committee Chair)
- 9.2.2 [Audit & Risk Committee Minute: 21/1/2022](#)
(Papers presented by Cllr Les Sharp, Committee Chair)
- 9.2.3 [Staff Governance Committee Minute: 10/12/2022](#)
(Papers presented by Mr Allan Rennie, Committee Chair)
- 9.2.4 [Clinical Governance Update: 22/2/2022](#)
[Clinical Governance Minute: 16/11/2021](#)
(Papers presented by Dr Michelle McClung, Committee Chair)
- 9.2.5 [Endowment Committee Minute: 21/01/2022](#)
(Papers presented by Cllr Les Sharp, Committee Chair)
- 9.2.6 [Area Clinical Forum Minute: 20/01/2022](#)
(Paper presented by Mrs Kirstin Cassels, Committee Chair)

10. ANY OTHER COMPETENT BUSINESS

10.1 Emerging Topics

11. DATE OF NEXT MEETING

Tuesday 31 May 2022 at 10.30am via MS Teams (TBC)

Closed Session Agenda – 29 March 2022

Item of business	Grounds for consideration in Closed Session as detailed within the Code of Corporate Governance
<ul style="list-style-type: none">Minute of the NHS Board Closed Session held on 25 January 2022	

FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

For Approval

Item 3 – DRAFT Minute of the Forth Valley NHS Board Meeting held on Tuesday 25 January 2022 at 10.30am via MS Teams

Present: Ms Janie McCusker (Chair)

Ms Kirstin Cassels
Mr Robert Clark
Cllr Fiona Collie
Mrs Cathie Cowan
Mr Martin Fairbairn
Dr Graham Foster
Mr John Ford
Mr Gordon Johnston

Mr Stephen McAllister
Cllr Susan McGill
Mr Andrew Murray
Mr Allan Rennie
Cllr Les Sharp
Mr John Stuart
Mr Scott Urquhart
Prof Angela Wallace

In Attendance:

Annemargaret Black, Director of Health & Social Care
Elsbeth Campbell, Head of Communications
Linda Donaldson, Director of Human Resources
Sinead Hamill (Minute), Board Secretary
Kerry Mackenzie, Head of Policy & Performance
Jackie McEwan, Corporate Business Manager
Gillian Morton, Director CPMO
Kathy O'Neil, General Manager
Jonathan Procter, Director of Facilities & Infrastructure
Phyllis Wilkieson, Acting Director of Acute Services

1. Apologies for Absence

The Chair welcomed everyone to the meeting.

Apologies were noted on behalf of Dr Michelle McClung

2. Declaration(s) of Interest(s)

There were no declarations of interest made.

3. Minute of Forth Valley NHS Board meeting held on

The minute of the meeting on Tuesday 30 November 2021 was approved as an accurate record.

4. Matters Arising from the Minute

The Board noted that there were no matters arising from the minute.

5. FOR APPROVAL

5.1 Revised Committee Structure

The NHS Board considered a paper 'Revised Committee Structure' presented by Mrs Cathie Cowan, Chief Executive.

NHS Board members noted that the NHS Forth Valley Assurance Committees had recently underwent revised changes in accordance with Standing Orders due to changes/new appointments in the Non-Executive NHS Board Membership.

Mrs Cowan identified that the Chair had met with NHS Board Members to discuss proposed changes. Non-Executive Board members commitments to NHS Forth Valley were considered during the revised changes. Board members noted that Vice Chairs will be appointed by the NHS Board Chair to each of the Assurance Committees in line with the Code of Corporate Governance approved by the NHS Board - November 2021.

Board Members noted that further work will be undertaken after Local Authority Elections to review NHS Board Representative for Clackmannanshire and Stirling Integration Joint Board. Mrs Cowan identified that the Local Authority Election will take place May 2022 where local authorities will make appointments to their Internal Committees, including appointing a Health Board Representative.

Mrs Cowan identified that changes to the Assurance Committees Terms of References will be made if the paper is supported by NHS Board Members.

Mr Procter wished to highlight that there had been National Governance changes to Endowments. Board members noted that there will be significant national policy changes in regard to endowments.

The Forth Valley NHS Board:

- ***Approved the Revised Committee Structure for 2022/23***
- ***Approved the change in membership to the Clackmannanshire/Stirling Integration Joint Board***
- ***Approved the changes in membership to the Falkirk Integration Joint Board***

5.2 ED Improvement Action Plan – Update Report

The NHS Board considered a paper 'ED Improvement Action Plan - Update Report' presented by Mrs Cathie Cowan, Chief Executive.

Board members noted that the ED Improvement Action Plan was formally approved by the NHS Board on the 6 August 2021. The Board paper including the Plan was also presented to the Integration Joint Boards (IJBs).

The established ED Oversight and Assurance Sub Committee chaired by the NHS Board Chair met in line with the agreed governance arrangements as set out in the approved Terms of Reference.

Mrs Cowan thanked NHS Board Directors for their roles in leading and implementing work in the following Governance areas:

- Nursing Workforce and Professional Oversight of Safe Staffing led by Prof Angela Wallace, Executive Nurse Director
- Clinical Governance led by Mr Andrew Murray, Medical Director
- Staff Governance led by Miss Linda Donaldson, Director of Human Resources
- Corporate Governance led by Mrs Cathie Cowan, Chief Executive

The Implementation from the ED Improvement Action Plan had been shared regularly with the NHS Board along with updates to the NHS Board's Assurance Committees. The overall investment to date for ED and wider system changes were noted at £0.778m to support a culture of improvement, learning and quality.

Mrs Cowan in her presentation referred to the progress in each of the governance areas.

13 Recommendations were noted for the Nursing Workforce and Professional Oversight of Safe Staffing. Mrs Cowan identified that 1 of the 13 recommendations was an additional NHS Board recommendation. Board members noted the completion of 6 recommendations with a further 5 recommendations making good progress. A total of £0.411m of investment was noted enabling NHS Forth Valley to recruit a Clinical Nurse Manager and a number of additional staff members to support an enhanced skill mix.

13 Recommendations were noted for Clinical Governance. Mrs Cowan identified that 2 of the 13 recommendations were additional recommendations. Board members noted the completion of 7 recommendations with a further 6 recommendations making good progress.

12 Recommendations were noted for Staff Governance. Mrs Cowan identified 3 of the 12 recommendations were additional recommendations. Board members noted that 9 recommendations had been completed with a further 3 recommendations making good progress. Board members noted that both the report and the action plan had been shared with staff side representatives on the 23 November 2021 to allow staff side to seek assurance. Mrs Cowan referred to the independent HR review and the system/process recommendations which would be also reported through the Staff Governance Committee and thereafter to the NHS Board.

Mrs Cowan as the owner of Corporate Governance highlighted 8 recommendations. Board members noted the completion of 5 recommendations with the other 3 recommendations on track.

Mrs Cowan in her concluding remarks referred to the recommendations from the ED Oversight & Assurance Sub Committee to delegate ongoing scrutiny and assurance to each of the NHS Board's Assurance Committees. If supported each Assurance Committee would be expected to prepare an update to the NHS Board with a focus on impact and effectiveness of recommendations implemented, and the monitoring and escalation of recommendations not implemented. Mrs Cowan also highlighted that an independent review by internal audit would be progressed to look at the implementation process and communications handling.

Prof Wallace highlighted that the recommendations throughout the review for Nursing Workforce and Professional Oversight of Safe Staffing were largely based on staff

members experience throughout the Emergency Department. Board members noted that both Mrs Cowan and the Chair Ms McCusker met with members of staff from ED resulting in additional recommendations being identified which were then approved by the NHS Board.

Board members noted that a workforce tool was run by NHS Forth Valley to inform staffing and skill mix investments.

Board members noted that the investment in a dedicated Clinical Nurse Manager post and this would provide an additional layer of supervision and leadership support.

Mr Murray wished to confirm that not all the recommendations covering clinical governance will sit with the Clinical Governance Committee, notably the redesign of unscheduled care - this currently reports through the Performance & Resources Committee, this was supported.

Miss Donaldson provided an update on Staff Governance by highlighting the iMatter tool for Employee engagement. Miss Donaldson highlighted the enhanced staff side engagement including additional Area Partnership Forum meetings including weekly engagement meetings with staff side and HR.

Organisational staff induction had been refreshed and work to resolve the Band 2 to 3 roles was progressing both nationally and locally.

The Chair wished to acknowledge the progress made to date and looked forward to receiving regular updates on the impact of the changes implemented and how these also related to staff wellbeing.

Mr Fairbairn wished to seek clarification on reporting arrangements going forward from the recommendations along with the impact. Mrs Cowan referred to the Board paper and the recommendation from the ED Oversight & Assurance Sub Committee to delegate ongoing scrutiny and assurance to each of the NHS Board's Assurance Committees. If supported each Assurance Committee would be expected to prepare an update to the NHS Board with a focus on impact.

Cllr Collie wished to receive information on who will have oversight to make sure that there is no disconnect once the recommendations are distributed to Board Committees. Mrs Cowan informed Board members that as the owner of the improvement plan, she will continue to be the accountable officer for the work. Board members noted that a summary report will be brought to the Board May 2022 and then quarterly going forward to allow Board members to have oversight of the ongoing implementation and impact of the changes as referred to earlier by the Chair.

Mr Stuart wished to seek clarity on protective learning time for Nursing staff. Mrs Cowan informed Board members that the Board had added this recommendation to the Plan and have a commitment to ensure nursing staff are on a par with medical staff working in ED. Work is underway to achieve this.

Ms Cassels wished to highlight that Prof Wallace attended the last Area Clinical Forum meeting where members were assured of the progress being made in Prof Wallace's area of responsibility.

Mr Clark informed Board members that Staff Side Representatives applaud the NHS Board for taking on the recommendations from the External Report and adding more having listened to staff. Board members noted that Staff side worked very hard to help

implement and challenge the NHS Board to ensure the Plan having been approved is being implemented. Mr Clark also wished to highlight that Staff Side Representatives attend the Board Assurance Committees and will seek assurance and provide scrutiny.

Mr Johnstone acknowledged the Internal Audit process and wished to know the timescale and when the outcome will come to the NHS Board. Board members noted that the scope of the Internal Audit review will firstly be shared with Sub Committee members from the Oversight and Assurance Committee for virtual approval and thereafter shared with Board members for information at this stage.

Mr Ford wished to know if there will be any intention to have KPIs. Mrs Cowan agreed that KPIs were important, and that consideration needed to be given to 'impact' by each of the governance leads and captured in future NHS Board reports.

NHS Board members acknowledged the overall progress as being excellent, identifying the number of completed recommendations from the Improvement Plan.

The Forth Valley NHS Board:

- ***Considered the assurance provided in the presentation to the Board regarding the effective implementation of actions to address the recommendations set out in the ED Improvement Action Plan (includes those recommendations added by the Health Board)***
- ***Considered the further improvements in system and processes referred to in the presentation to the Board as identified following an external HR review***
- ***Endorsed the proposal from the ED Oversight and Assurance Sub Committee to delegate scrutiny and assurance for the ED Improvement Action Plan ongoing implementation and associated risks to the Health Board's designated Assurance Committees (Nursing Workforce and Professional Oversight to the Performance & Resource Committee; Clinical Governance to the Clinical Governance; Staff Governance and HR review findings to the Staff Governance Committee, and Corporate Governance to the Policy & Resources Committee) and invite the Chief Executive to present a quarterly report on progress as set out in the paper***
- ***Noted the request to Internal Audit (subject to approval by the ED Oversight & Assurance Sub Committee members) to undertake a review of the commission of the ED External review by the Accountable Officer/CEO of the Health Board, governance arrangements including the establishment of a Board Sub Committee to oversee the implementation of the ED Improvement Action Plan and reporting to Assurance Committees and Area Partnership Forum and internal (reporting to the Board's Assurance Committees and Area Partnership Forum (APF)) and external communications***
- ***Noted the ongoing OD work to provide support and development of ED staff***

6. BETTER CARE

6.1 Pandemic Update

The NHS Board considered a paper 'Pandemic Update' presented by Dr Graham Foster, Director of Public Health.

Dr Foster informed Board Members of the arrival of the Omicron Variant which had originally been identified in South Africa. A high peak of Omicron was identified throughout the Forth Valley area over the Christmas period. Dr Foster informed the

Board that the peak had begun to fall, and he was pleased to identify that the peaked had occurred much sooner and at a less high level than the initial modelling data had suggested.

Board members noted that the combination of measures in place had an effect on the peak of Omicron along with Lateral Flow testing which had made a big difference with trying to control the spread of the virus. Dr Foster highlighted that the COVID vaccination booster programme had been brought forward. This had also been effective with Dr Foster wishing to thank and congratulate those who had delivered the vaccination programme. The need to continue the measures in place for COVID was acknowledged as Board Members noted that COVID had not disappeared.

Dr Foster also wished to give a huge thanks to NHS Forth Valley's Test and Protect Team and Testing teams who had worked very hard over Christmas and New Year to keep everyone safe.

Mr Stuart wished to seek clarity on the Anti-Viral Medication for COVID and if community pharmacists would be involved. Dr Foster informed Board members that the Anti-Viral medication will be supplied to high-risk individuals who contract COVID-19 and are symptomatic. Board members noted that those identified as being high risk had been issued a letter with information and a contact number.

Cllr Sharp identified that he had been asked by community members if a 4th Covid vaccination booster will be issued. Dr Foster highlighted that there had been no decision regarding a 4th dose however decisions may be visited over time.

Mr Rennie wished to understand hospital restrictions due to COVID. Prof Wallace informed Board members that due to the impact of COVID some Board's made the decision to go to 'essential visiting'. NHS Forth Valley were able to keep visiting arrangements in place for a longer time. Board members noted that visiting restrictions remain a mixed picture, but the Scottish Government are keen for visiting to be restored safely.

Cllr Collie wished to highlight the excellence of NHS Forth Valley Test and Protect Service who were very efficient when she had contracted the virus. Cllr Collie also wished to seek clarity regarding the Flu Campaign. Dr Foster informed the Board that the Flu Campaign is currently not needed as there had been no significant increase of flu cases within the UK.

The Forth Valley NHS Board:

- ***Considered this public health update describing overall progress with responding to the pandemic and the latest updates for Forth Valley***

6.2 Healthcare Associated Infection Reporting Template

The NHS Board considered a paper 'Healthcare Associated Infection Reporting Template' presented by Prof Angela Wallace, Executive Nurse Director.

Prof Wallace informed the Board that the HAIRT report presented highlighted no key issues for concern – with all measures remaining within control limits.

Prof Wallace highlighted that Infection control are not carrying out routine ward visits due to system pressures and COVID. Board members noted that infection control is

still visiting wards to provide additional support and advice and an unannounced visit from Health Care Improvement Scotland was also noted.

Board members noted the focus on care homes with Prof Wallace continuing to chair the oversight arrangements to support care homes.

Prof Wallace identified that both December and January had been a difficult period due to COVID outbreaks but assured Board members that only a small number of outbreaks had occurred and had been managed well.

The Forth Valley NHS Board:

- ***Noted the HAIRT report***
- ***Noted the performance in respect of the AOP Standards for SABs, DABs, CDIs & ECBs***
- ***Noted the detailed activity in support of the prevention and control of Health Associated Infection***

6.3 Recovery & Performance Scorecard

The NHS Board considered a paper 'Recovery and Performance Scorecard' presented by Mrs Cathie Cowan, Chief Executive.

Mrs Cowan wished to highlight for new Non-Executive Board Members that the Recovery Scorecard takes into account the System Wide Remobilisation Plan and the reestablishment of services. Board members noted that the Scorecard is circulated to both the System Leadership Team and non-executive board members on a weekly basis along with a full monthly update to the Performance and Resources committee. Performance reporting through the wider Corporate Management Team continues.

Mrs Cowan wished to highlight areas where performance was below acceptable levels for NHS Forth Valley. Board members noted the challenges in unscheduled care which reflected the pressures on both the health and care systems. The 4-hour access standard performance had improved when compared to the December position of 58.3% and the January position of 70%.

Board members noted that the support provided by the Scottish Government for flow 3 (discharges improvement support) requested by Mrs Cowan is going well with Silver Command leads working in partnership to support improvement work. Mrs Cowan identified that there is work still to be carried out for unscheduled care, but Mrs Cowan and Mr Murray are working closely with the team to support the process.

Mrs Cowan highlighted the hospital occupancy challenges because of the imbalance between admissions vs discharges. Board members noted the 84 delayed discharges across NHS Forth Valley with an additional 35 patients in the acute sector waiting to be transferred to a social care or NHS Bed to support their recovery journey. Mrs Cowan highlighted the pressures experienced in Health and Social Care Partnerships which were impacting on supporting discharges. Mrs Cowan also wished to highlight the number of health and care staff having to self-isolate which added to the challenges across the health and care system.

Mrs Cowan also wished to highlight Psychological Therapies performance for December which was below target at 52.6% although there had been data collection issues. Board members noted that investment had been made by the Scottish

Government to allow NHS Forth Valley to recruit staff to improve performance. An improvement was noted for CAHMS performance for December achieving 69.2% with patients starting treatment in 18 weeks.

(Post meeting update as shared with Board members – Psychological Therapies for December was above target – 67.8%)

Mrs Cowan invited Ms Kerry Mackenzie Head of Policy and Performance to provide an update. Ms Mackenzie informed Board members that work is ongoing to deliver activity despite the significant challenges from COVID. Board members noted that during December both outpatient and inpatient activity exceeded the plan which identified an overall improved position.

Board member noted that NHS Forth Valley diagnostics position for December 2021 was not positive with activity being below planned levels, particularly endoscopy at 61%. Ms Mackenzie informed the Board that there was an increase of patients who did not attend appointments over the festive period. Board members noted that the service to be running at full capacity with 43 lists a week.

Ms Mackenzie noted that imaging also experienced a challenge with a high number of radiology staff self-isolating over Christmas which extended beyond New Year.

An increase in patients waiting beyond 6 weeks for imaging was noted at the end of December 2021 with pressure on ultrasound services and CT scanning. A slight reduction for those waiting for ultrasounds noted. Ms Mackenzie highlighted that patients continue to be seen on a priority basis.

The Board noted the DNA rate at 10-12% over the last couple of weeks for Ultrasound and CT which was higher than previous periods. Ms Mackenzie informed the Board that activity continues to be monitored on an ongoing basis.

Ms Wilkieson wished to assure Board members that the manager for Radiology, Ms Jennifer Gilchrist had been working closely with NHS Lothian to seek additional support. Board members noted that there was a significant rise of referrals in December which added to the challenges facing imaging.

A significant number of patients for the 62-day pathway for Cancer Services continued to be tracked. Ms Mackenzie informed the Board of the progress made in November 2021 against the 62-day target which was noted at 80.3%. Board members noted that NHS Forth Valley continues to meet the 31-day target.

An update from Cancer services was presented to the Performance and Resources Committee - August 2021. Board members noted that a further update was requested to be shared March 2022 which will also be shared with Board members.

Cllr Collie asked for clarity regarding the monitoring of the attendance rates. Mrs Cowan informed the Board that work had been carried out with patients receiving text message reminders. Board members noted that the number of DNA rates over both Christmas and New year. Board members also noted that these DNA rates were lost appointments for people who were also waiting to be seen.

Mr Rennie wished to know if any campaigns are being used to highlight the costs and impact of disruption if patients do not attend their appointment. Mrs Campbell wished to reassure Board members that changes had been made in relation to communicating with patients regarding their upcoming appointments. The importance of not turning up to appointments had been highlighted throughout appointment letters along with text

message reminders highlighting the importance to get in contact if they are not able to attend their appointment. Mrs Campbell also highlighted that these changes had only recently been made and she was optimistic that this would result in DNA reductions.

Ms Wilkieson wished to add that NHS Forth Valley have colleagues working with Head of Services to try and remind patients of their appointments.

Mr Ford wished to seek clarity if DNA is a figure gross. Mrs Cowan confirmed that in some specialties the rates were higher and lower and that she would share specialty DNA rates with Board members.

Mr Murray informed Board members that if a patient phones before their appointment to inform that they are not able to attend that they are put down as CNA to allow their space to be filled.

Mr Stuart wished to see an improvement plan for diagnostic waits. Ms Wilkieson proposed to share an improvement plan with the Board or Board Committee. The Chair suggested that the improvement plan may be best to go through the Clinical Governance Committee and thereafter to the Board.

Ms Mackenzie wished to inform Board members that the access policy and this would be presented to the Performance & Resources Committee.

The Forth Valley NHS Board:

- ***Noted the current key performance issues***
- ***Noted the detail within the Recovery & Performance Scorecard***

7. BETTER VALUE

7.1 Finance Report

The NHS Board considered a paper 'Finance Report' presented by Mr Scott Urquhart, Director of Finance.

Mr Urquhart informed Board members that the Finance report provides assurance and an update of the financial position and the projection for NHS Forth Valley year end. Mr Urquhart identified that NHS Forth Valley remain on track to deliver both capital and revenue requirements for this financial year.

Board members noted that the system pressures translate to the financial impact identified particularly throughout workforce cost.

The impact of having to cover staff absences because of covid and self-isolation was noted along with additional staff capacity to meet demands. Board members noted that the Scottish Government had committed to funding the impact of additional costing. Regular financial monitoring continues along with a financial report in place across all key areas of spend.

An update on Financial Planning had recently been presented to the Performance and Resources Committee in relation to the Scottish Budget announcement in December 2021. Board members noted that the announcement confirmed the baseline uplift funding for the new financial year. Mr Urquhart informed Board members that a further update will be taken to the Performance and Resources Committee in March 2022.

Board members noted that the final financial plan and saving programme will be brought to the Board March 2022 for approval.

Mr Johnston wished to seek clarification on the Boards position on Prison Healthcare. Mr Urquhart identified that a case was submitted to the Scottish Government with a further update being submitted. Board members noted that Mr Urquhart had not seen any detailed response.

Ms O'Neil informed Board members that discussion with the Scottish Government is still undergoing in terms of funding to support the HMP Stirling development. Mrs Cowan confirmed that she would liaise with Scottish Government and request an update.

Mr Fairbairn asked Mr Urquhart to update on the aspirations for progressing the savings requirements as set out in paragraph 1.4. Mr Urquhart informed Board members that a further update will be taken back to the Performance and Resources Committee in relation to the plan and reported thereafter to the Board.

The Forth Valley NHS Board:

- ***Noted a projected break-even financial position against revenue and capital resource limits for 2021/22 year-end, subject to key risks highlighted in the report***
- ***Noted an overspend of £0.018m for the eight-month period to 30th November 2021***
- ***Noted the updated assessment of annual COVID-19 related costs and funding, with a further return to be submitted to Scottish Government in January***

8. BETTER GOVERNANCE

8.1 Blueprint for Good Governance

The NHS Board considered a paper 'Blueprint for Good Governance' presented by Mrs Cathie Cowan, Chief Executive.

Mrs Cowan highlighted that the Blueprint for Good Governance will be brought to the Board regularly to provide an update. Board members noted that the Governance Improvement Plan and the actions, related outcomes, and timescale in each of the governance themes.

Mrs Cowan proposed for an extension until the end of March 2022 for the Assurance Strategy to develop a Board Assurance framework.

Mrs Cowan informed Board members that NHS Forth Valley are keen to carry out a stakeholder event in relation to the Strategic Governance Theme. Board members noted that a session with Health and Improvement Scotland to help inform the Healthcare Strategy refresh. Mrs Cowan proposed for Board members to extend the Strategic Governance theme until March 2022 to allow the stake holder event to be carried out.

Board members noted the Generative Governance theme which focused upon the aspiration of the future strategic priorities. Mrs Cowan identified that some work had been completed for the Generative Governance theme.

Board members noted that Mr Murray continues to update the Visibility programme at pace. Mrs Cowan identified that she is also thoughtful about when we support the 'big conversation' and connect with staff. Non-Executive Board members will be critical to this work.

Mrs Cowan also highlighted the work to support the roll out of iMatter and how it connects with the culture and leadership to support a learning organisation with compassion at its core and Miss Donaldson and her team will key to supporting this work. Miss Donaldson informed the Board that Board values need to be revisited. Board members noted that NHS Forth Valley were anticipating that the Scottish Government were going to deliver the National Health and Care Workforce strategy.

Miss Donaldson highlighted that there are individuals who are not happy with the iMatter tool. The main element of the tool was identified with quality conversations being carried out afterwards. Board members noted that the Staff Governance Assessment tool issued to all Directors on the 3 October 2022 are due to be completed.

Miss Donaldson identified the relaunch of the Staff Wellbeing group in October 2021. Board members noted the importance of developing a staff wellbeing plan which Miss Donaldson had now received and will be sharing soon.

The importance of developing a value setting process was noted with the launch of the Speak Up Initiative and Whistleblowing in place for NHS Forth Valley. The importance to evaluate the processes was noted.

Mr Fairbairn identified unrealistic timeframes and wished to seek clarity that the work will be continued with extra time provided if needed to achieve the work. Mrs Cowan was confident that progress can be made subject to how the pandemic evolved.

Mr Stuart wished to seek clarity regarding what the big conversation will look like. Mrs Cowan highlighted that she would like Non-Executive Board members to pair up with directors to visit different areas of the health board and to hear directly from staff over a coffee or cup of tea. Board members noted with the easing of restrictions it may be possible to carry this out very soon.

The Forth Valley NHS Board:

- ***Considered the key issues set out in the paper***
- ***Sought assurance on the work underway to deliver on the actions approved by the NHS Board***
- ***Requested a future update report***

8.2 Best Value Framework

The NHS Board considered a paper 'Best Value Framework' presented by Mr Scott Urquhart, Director of Finance.

Mr Urquhart identified that the Best Value Framework was brought to the Board for assurance. Board members noted the purpose of the report which demonstrates arrangements in place to report best value and continue to deliver improvement and performance.

A number of cross references throughout the report were noted against a number of key themes. Mr Urquhart informed Board members that there are 5 key themes outlined throughout the report along with 2 cross cutting themes. Board members noted that there are a number of requirements for each theme which is demonstrated with evidence and outcomes in the report.

Mr Urquhart informed Board members that there is some further work to be carried out in relation to assurance mapping which had begun with a deep dive on the Strategic Financial risk. Mr Urquhart wished to pay credit to Ms Mackenzie for writing the report.

Ms Mackenzie informed Board members that the Equality Strategy was approved by the Board July 2021. The Equality Strategy supports a culture with continuing improvement and with quality being everyone's business.

An initial draft on an assurance report had been presented to the Performance and Resources Committee 18 January 2022. It was agreed at the Performance and Resources committee that the Assurance Report would be presented at a Board Seminar to allow further discussion and to agree the layout along with an agreement of what the final document will look like.

Mr Procter wished to seek clarity that the Health and Safety strategy was included throughout wellbeing. Miss Mackenzie informed that this is noted throughout the paper.

The Forth Valley NHS Board:

- ***Noted the detail within the Best Value Framework Summary***
- ***Noted the Best Value Framework summary was considered and accepted by the Audit & Risk Committee on 21 January 2022***

8.3 Clackmannanshire & Stirling HSCP Annual Performance Report

The NHS Board considered a paper 'Clackmannanshire & Stirling HSCP Annual Performance' presented by Ms Annemargaret Black, Chief Officer Clackmannanshire & Stirling HSCP.

Ms Black informed Board members of the Integration Joint Board (IJB) strategic planning, commissioning and oversight responsibilities for those delegated Health and Social Care functions and budgets across Clackmannanshire and Stirling. Board members noted that both the Health Board and Councils have service delivery responsibilities for service delivery for those functions delegated to the IJB.

NHS Forth Valley continue to have strategic planning (working with Chief Officers), budget management and operational responsibilities for services that sit within the set aside arrangements. Ms Black identified that Clackmannanshire IJB had oversight of the Health and Social Care system performance to fulfil its strategy responsibility.

Board members noted that the impact of the pandemic since March 2020 continues to be monitored. An impact on unpaid carers had been identified by carers. Ms Black noted satisfaction scores may be reduced with continuing significant demands across Health and Social Care services.

Ms Black informed the Board that areas of improvement had been identified for performance managed in the Health & Social Care Partnership. During the period from April 2020 until March 2021 all services have been impacted and this will impact on performance.

Ms Black shared a videoclip to the Board which identified Stirling & Clackmannanshire care home assessment and response team. The Board noted that the response team had went on to be finalists for the National Care Award and COSLA Award. Board members wished the Team well.

Board members noted the performance to connect with financial information. Ms Black informed Board members that both she and Ms Patricia Cassidy had been meeting with NHS Forth Valley colleagues to progress a transfer of operational management to underpin a financial overview.

Prof Wallace wished to highlight that the videoclip shared illustrated the culture and potential which can be done together during difficult circumstances.

Cllr Collie acknowledged both the report and videoclip whilst appreciating the difficulty in reporting the outcomes. Cllr Collie also identified the idea of collecting stories which are important to give examples of what had been achieved. Cllr Collie wished to seek clarity on how the best quality of care is carried out throughout Care at Home services. Ms Black identified that oversight arrangements had been set up for Care at Home services allowing for development.

The Forth Valley NHS Board:

- ***Noted the activity outlined within the Draft Annual Performance Report 2020 /2021.***

8.4 Governance Committee Minutes

8.4.1 Performance & Resources Committee Minute: 31/08/21

The NHS Board noted the assurance provided through the minutes of the Performance and Resources Committee Meeting 31/08/21.

8.4.2 Audit & Risk Committee Minute: 22/10/21

Mr Urquhart wished to highlight the National Payroll Services and identified that a further update will be provided to the next Performance and Resources Committee meeting in relation to the contractual quality and payment arrangement.

The NHS Board noted the assurance provided through the minutes of the Audit and Risk Committee Meeting 22/10/21.

8.4.3 Staff Governance Committee Minute: 17/09/21

Mr Rennie highlighted the staff absence rate which had been discussed at the Staff Governance Committee meeting. Board members noted that COVID was contributing to absence rates.

Board members also noted that the Whistle blowing framework is now in place. The Speak Up initiative was also noted and in place which encourages and promotes staff to speak up in a safe and supportive manner.

NHS Forth Valley had not being using TURAS extensively given its limitations for recording the national objectives, Board members noted that this will be reviewed for next year.

The NHS Board noted the assurance provided through the minutes of the Staff Governance Committee Meeting 17/09/21.

8.4.4 Area Clinical Forum Minute: 18/11/2021

Mrs Cowan identified that the Remobilisation plan had been well received at the Area Clinical Forum meeting. Mrs Cowan wished to register with the Board the professions thanks in the meeting as NHS Forth Valley had invested in supporting the advisory committee groups by providing support including administration services.

The NHS Board noted the assurance provided through the minutes of the Area Clinical Meeting 18/11/21.

9. ANY OTHER COMPETENT BUSINESS

There being no other competent business the Chair Closed the meeting.

FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

6.1 Financial Plan 2022/23 to 2026/27 For Approval

Executive Sponsor: Mrs Cathie Cowan, Chief Executive

Author: Mr Scott Urquhart, Director of Finance

Executive Summary

This report sets out five-year revenue and capital financial plans for NHS Forth Valley.

Recommendation

The NHS Board is asked to

- **approve** the Financial Plan 2022/23 – 2026/27 detailed in Annex A
- **approve** the Capital Plan 2022/23 – 2026/27 detailed in Annex B
- **approve** the 2022/23 budgets for Integration Authorities
 - Falkirk £ 170.853m
 - Clackmannanshire/Stirling £ 155.125m
- **approve** the cost improvement plan and approach
- **note** the financial risks highlighted for 2022/23 and for future years
- **note** the ongoing financial impact of Covid-19 and the requirement to contain spend within available resources

Key Issues to be considered

Issues are highlighted within the attached report

Financial Implications

Any relevant financial implication will be discussed within the report

Workforce Implications

Any workforce implications will require to be considered as the next stage of the planning process

Risk Assessment

Key risks are highlighted within the appropriate level of Risk Register including Corporate Risks

Relevance to Strategic Priorities

There is a statutory requirement for NHS Boards to ensure expenditure is contained within the Revenue Resource Limit (RRL) and Capital Resource Limit (CRL)

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process. Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity

Consultation Process

Executive Leadership Team / Performance and Resources Committee

NHS Forth Valley

Financial Plan 2022/23 – 2026/27

Executive Summary

This report provides an overview of capital and revenue financial plans for NHS Forth Valley. The plans set out how available funding will be directed to support delivery of the NHS Board's strategic objectives and to mitigate strategic risks, including targeted savings and efficiency plans to deliver a balanced budget in line with Scottish Government requirements.

The 2022/23 Financial Plan is based on a one-year transitional funding settlement detailed in the Scottish Government indicative allocation letter of 9th December 2021. Projections for future years from 2023/24 are presented on a planning basis and will continue to be updated as more detailed information is made available, with a full resource spending review expected to be published in May 2022.

The level and scale of financial challenge has increased over the course of the pandemic and a focused whole-systems approach is required to embed innovation, quality, and efficiency in delivering service plans aligned to recovery. Recurring investment priorities approved by the NHS Board in 2021 to support sustainable improvements in patient and population health outcomes will continue to be implemented on a phased basis.

Savings of £29.3m (5.1% of baseline) will be required to balance the financial plan in 2022/23. This position carries a significant level of financial risk and uncertainty with continued response to the pandemic and an acknowledgement that staff absence, vacancies and additional capacity requirements continue to drive an increased level of supplementary workforce costs across the unscheduled care pathway. The level of risk in meeting the full savings requirement is high, and non-recurring sources will require to be identified to bridge any recurring savings gap in year.

During 2021/22 a Cost Improvement Oversight group was established with Project Management Office support, to direct and oversee delivery of savings, efficiency, and value opportunities. This will continue into 2022/23 with an early focus on resetting core financial and budgetary controls, supporting the expansion of those savings schemes already successfully in place, and engaging with staff teams across services to develop new options. A process for developing a future pipeline of cost improvement schemes through structured programme mandates has been established.

Additional in-year funding is anticipated to support costs directly associated with Covid-19 and spend will require to be contained within available resources once confirmed.

A five-year capital plan is attached at Annex B which details the investment priorities and budgets for the five-year period 2022/23 – 2026/27.

Funding

The 2022/23 initial allocation letter confirms a core baseline budget uplift of 2.0%, plus £4.6m towards maintaining NRAC parity and a £3.2m contribution for employers national insurance uplift. Further targeted funding for improving patient outcomes is expected to be confirmed across individual policy areas. Funding uplifts for years beyond 2022/23 are based on planning assumptions at this point.

Exhibit 1

NHS Board Initial Revenue Allocation 2022/23

	£ million
Baseline budget: 2021/22 Revenue Allocation	578.782
2.0% Core uplift	11.576
NRAC Funding	4.600
Employers National Insurance Contribution Uplift	3.200
Total Initial Budget 2022/23	598.158

The NRAC (National Resource Allocation) formula is used to calculate the proportionate share of funding across each NHS Board based on population statistics adjusted for demographic and other factors. The 2022/23 indicative allocation letter confirmed that those Boards furthest from NRAC 'parity' (the calculated share of national NHS resources) would receive a share of £28.6m to maintain all Boards at within 0.8% of parity. NHS Forth Valley's funded allocation from that resource is £4.6m.

The allocation letter also confirmed additional funding for NHS Scotland of £845.9m (an annual increase of £70.0m) for improving patient outcomes, including investment for Mental Health and CAMHS, Primary Care priorities and improvement in Waiting Times. Allocations for individual Boards have not yet been confirmed at this stage and further information will be provided to the NHS Board once this has been established.

Non-recurring (n/r) funding to support delivery of specific service priorities is anticipated, at values broadly similar to those in 2021/22, with the exception of n/r new drugs funding which has increased beyond prior year levels. Budget for the National Treatment Centre and other planned care initiatives in NHS Forth Valley will be met on an in-year basis aligned to recruitment timescales and consumables costs.

The process developed during the last two years for identifying and reporting Covid-19 related costs will continue into 2022/23 and those costs will require to be managed within the available funding resource which is subject to further confirmation. Recurring funding has been made available to support permanent recruitment of vaccination staff. Non-recurring funding for Test and Protect services will continue for a further six-month period.

Costs

In preparing the 2022/23 Financial Plan cost inflation projections have been based on known positions where available or best estimates benchmarked with other NHS Boards for consistency and reviewed with colleagues locally in assessing sensitivity and risk of assumptions.

The areas of highest potential variability on unit price in future years include energy tariffs, new drugs or therapies (particularly those targeting rarer conditions), and pay rises, which directly influences staffing costs. Projected changes in demographic profiles are also expected to influence expenditure trends.

Exhibit 2

Cost Inflation Projections 2022/23

Category	% on base
General Pay Inflation (aggregate)	2.17
General Price Inflation	2.00
Unitary Charge Inflation	6.00
Energy	25.00
Prescribing – community	5.50
Hospital Drugs	7.00

Expenditure on workforce accounts for 47% (£340m) of total NHS Forth Valley costs and is the NHS Board's largest area of spend. Projected pay inflation costs for 2022/23 are based on the pay metrics set out in the Public Sector Pay Policy report published in December 2021. Each 1% of movement in pay award has a £3.4m impact on cost base.

Expenditure on medicines account for 16% (£110m) of total NHS Forth Valley costs of which 60% is spent through GP Prescribing and 40% through hospital sources and this continues to be a key area of focus for cost improvement in 2022/23 following successful cost and quality improvement initiatives in previous years,

Price inflation remains subject to market and economic conditions particularly given the wider global economic impact of Covid-19 pandemic and in response to current world events. Approved local investments including Healthcare at Home, Neurovascular services, and sustainable delivery of waiting times improvements continue to be phased in on a planned basis and have been factored into cost projections.

Technological advances including artificial intelligence, robotics, genomics and precision medicine, remote care and technology supported self-management are expected to significantly impact on the shape and direction of future healthcare services and associated costs in future.

Integration Authority Budgets

The indicative allocation letter confirmed that NHS payments to Integration Authorities in 2022/23 for delegated health functions must deliver an uplift of at least 2.0% over 2021/22 agreed recurring budgets and make appropriate provision for increased employer National Insurance contribution costs. The contributions to Integration Authorities per Exhibit 3 meet this requirement.

In addition, and separate to the uplift funding, the Health and Social Care Portfolio of Scottish Government will invest a further £554m nationally to support Adult Social Care and integration.

Exhibit 3 Proposed Integration Authority Budgets 2022/23

Category	Falkirk £million	Clacks/Stirling £million
<u>Baseline budget: 2021/22</u>		
Set Aside	30.229	24.036
Operational budgets	49.611	38.289
Universal budgets (Prescribing / Family Health Services)	33.039	33.345
Integration Funding (Pass Through)	10.206	8.943
Transformation Funding	1.544	3.272
	124.629	107.886
<u>Uplift Calculation</u>		
2.0% Core Uplift	2.493	2.158
Employers National Insurance Contribution Uplift	0.428	0.345
Universal Funding - outwith recurrent baseline	43.304	44.737
Total Initial Budget 2022/23	170.853	155.125

Additional non-recurring allocations for health functions delegated to the Integration Authorities and which are ring-fenced, will be added to the budget as those are confirmed.

The funding for 'Set Aside' services is provided to the Integration Authorities for Strategic Planning purposes and the operational budget remains with the NHS Board. A full review of budgets aligned to set aside functions was undertaken during 2021 and

budgets have been updated accordingly. Work on developing a model to respond to activity and cost movements for set aside services will continue during 2022.

For services included within Operational and Family Health Services categories the planning assumption is that budgets (with the exception of Resource Transfer) will be passed back to the Board under direction. These funds will then be included as funding received from Integration Authorities.

Both Falkirk and Clacks/Stirling Health and Social Care Partnerships have prepared Business Cases which set out their plans and financial risks for 2022/23. Following approval by respective Integration Join Boards, both cases were presented to the Performance and Resources Committee in January 2021. The Health Board has confirmed proposed 2022/23 funding uplifts to both IJBs in line with required timescales set out within the partnership Integration Schemes.

Savings Plans

Based on current resource and expenditure assumptions, savings of £29.3m (5% of recurring baseline) are required to deliver financial balance in 2022/23. Targeted plans to the value of £22.8m have been set across six themes are set out below, with an unidentified gap at this stage in the planning cycle of £6.5m after accounting for initial non-recurring opportunities. Given the current development stage of planning across these schemes a significant proportion of these plans have been assessed as high risk for 2022/23.

Exhibit 4 Savings Plans 2022/23

Savings Theme	Target £m
Service Redesign (including embedding approved investments)	£3.2m
Drugs and Prescribing – product switches and waste reduction	£3.8m
Workforce – rostering, job planning and substantive recruitment	£3.3m
Infrastructure, Innovation & Digital Developments	£2.0m
Integration Service Opportunities	£3.0m
Financial Management and Controls (including n/r options)	£7.5m
Total	£22.8m
Savings requirement	£29.3m
Unidentified Savings	£6.5m

The approach to savings delivery agreed by the Executive Leadership Team and recognising the current operating context, is to revisit and enhance key financial and workforce controls to stabilise the position, expand and support those savings initiatives which are already embedded, and to develop new pipeline initiatives through processes developed with CPMO colleagues.

3 Step approach to Cost Improvement



Financial Risks

The overarching financial sustainability risk is included within the NHS Board Strategic Risk Register and is regularly updated with mitigating actions and controls to minimise that risk as far as possible. A detailed deep dive into the strategic financial risk was presented to the Performance and Resources Committee in October 2021.

The key operational financial delivery risks in relation to the 2022/23 financial plan are summarised below. Further updates in respect of likelihood, impact and mitigation of financial risks will be presented as part of the monthly financial reporting process to committees.

- There is a risk that Covid-19 will continue to have a significant and far-reaching impact on the cost profile and workforce availability in 2022/23, and as a consequence costs cannot be contained within available resources. It will also have wider longer term economic, workforce and service impacts which are not yet clear.
- There is a risk that whole-system capacity and workforce pressures across health and social care services will result in an ongoing and increasing requirement for temporary supplementary beds and staff which will lead to a sustained increase in staff costs beyond budgeted levels which is unsustainable.
- There is a risk that price inflation rates will increase beyond anticipated levels which will have a direct impact on the cost of goods and services and a potential impact on PFI expenditure commitments, and as a consequence will increase the cost base.
- There is a risk that planned savings will not be delivered or will be delayed due to competing pressure on staff time and resources, and as a consequence there will be a shortfall on recurring savings and a continued reliance on non-recurring measures to deliver break even.
- There is risk that the introduction of new drugs and therapies will lead to an increase in treatment costs and demand beyond the level of additional funding which has been confirmed, which will lead to an affordability gap.

NHS Forth Valley has a disproportionately high prison population compared to its' general population and a proposal for additional funding has been made to Scottish Government to support associated healthcare needs and costs beyond the resources available.

Cost pressures associated with Health and Social Care Partnerships, particularly in respect of requirement to support additional payments beyond funded baselines, continue to reflect a financial risk.

Capital Plans

The five-year capital plan presents a balanced position in each year of the plan, based on agreed funding and prioritised areas of investment.

Funding

Core Capital Resources of £6.389m are anticipated for 2021/22 and in each of future years, supplemented by additional anticipated allocations within the plan including property sales and return of banked monies from prior years as detailed in Annex B which takes the 2022/23 annual Capital Funding to £10.357m.

Expenditure

The key elements of the NHS Forth Valley Capital expenditure plans are:

- Information Management & Technology: to support the priorities in the approved eHealth Strategy including software replacement and upgrades, new systems and digital developments.
- Medical Equipment: The Medical Devices Group has delegated authority to oversee the prioritisation of new and replacement medical equipment within a fixed budget of £2m per annum.
- Facilities and Infrastructure: Key infrastructure developments include Primary Care estate improvement, retained Community Hospital sites maintenance and development, fire safety measures, statutory standards compliance and backlog maintenance requirements

There are two further significant infrastructure developments which are being progressed through project oversight structures to develop cases for consideration by Scottish Government in line with the Scottish Capital Investment Manual (SCIM) processes. These are Falkirk Community Hospital redevelopment and the Primary Care premises investment programme.

Annex A – 5 Year Revenue Financial Plan

	Year 1 (2022/23)		Year 2 (2023/24)		Year 3 (2024/25)		Year 4 (2025/26)		Year 5 (2026/27)	
	%	Total £m	%	Total £m	%	Total £m	%	Total £m	%	Total £m
Summary of Costs										
Funding										
Base Uplift	2.00%	11.576	2.5%	14.954	2.5%	15.328	2.5%	15.711	2.5%	16.104
NRAC	0.79%	4.600								
Pay Consequentials										
Employers National Insurance Contribution Uplift		3.200								
Elective Capacity Development SEU-FV		8.910								
Access Targets		5.000								
New Medicines Fund		5.460								
Primary Care Fund		TBC								
Waiting Times Recovery Investment		TBC								
Mental Health & CAMH Funding		TBC								
Alcohol and Drugs Funding		TBC								
Health and Social Care Integration		TBC								
COVID-19 Funding (assumed all costs will be fully funded)		TBC								
Total Resource Increase		38.746		14.954		15.328		15.711		16.104
Costs										
Brought forward pressures		11.539		0.000		0.000		0.000		0.000
Pay & Prices Inflation										
Pay Inflation - Agenda for Change	2.24%	5.035	2.50%	5.746	2.50%	5.890	2.50%	6.037	2.50%	6.188
Pay Inflation - Medical	2.00%	1.415	2.50%	1.804	2.50%	1.849	2.50%	1.896	2.50%	1.943
Pay Inflation - Senior Managers	0.46%	0.010	2.50%	0.055	2.50%	0.057	2.50%	0.058	2.50%	0.059
Pay Inflation - Other	2.35%	0.025	2.50%	0.027	2.50%	0.027	2.50%	0.028	2.50%	0.029
General Price Inflation	2.00%	0.864	3.79%	1.115	3.74%	1.142	3.69%	1.169	3.65%	1.197
Unitary Charge Inflation	6.00%	2.410	3.50%	1.490	3.50%	1.542	3.50%	1.596	3.50%	1.652
Energy	25.00%	1.345	10.00%	0.672	10.00%	0.740	10.00%	0.814	10.00%	0.895
Rates	2.00%	0.126	2.00%	0.129	2.00%	0.131	2.00%	0.134	2.00%	0.137
Resource Transfer	2.00%	0.439	2.50%	0.560	2.50%	0.574	2.50%	0.588	2.50%	0.603
Voluntary Bodies / other providers	2.00%	0.063	2.50%	0.081	2.50%	0.083	2.50%	0.085	2.50%	0.087
External CBF Outflow	2.00%	1.085	2.50%	1.384	2.50%	1.419	2.50%	1.454	2.50%	1.490
External CBF Inflow	2.00%	(0.237)	2.50%	(0.303)	2.50%	(0.310)	2.50%	(0.318)	2.50%	(0.326)
Prescribing - Community	5.50%	3.273	5.50%	3.453	5.50%	3.643	5.50%	3.844	5.50%	4.055
Hospital Drugs	7.00%	2.732	7.00%	2.924	7.00%	3.128	7.00%	3.347	7.00%	3.582
Other Pay Costs (incl employers NI contribution uplift)		5.261		0.127		0.130		0.134		0.137
Other Non Pay		0.732		0.037		0.039		0.040		0.041
Drugs and Medicines		5.800		1.024		0.095		0.102		0.109
Demographic Change		0.000		3.500		4.000		4.500		5.000
Non Demographic Growth		0.000		2.250		2.750		3.250		3.750
eHealth		1.621		0.576		0.589		0.546		0.777
Property		0.525		0.013		0.013		0.014		0.014
Capacity & Flow (SEU-FV and WT)		13.910		0.000		0.000		0.000		0.000
Local Developments/ Investments/ Initiatives		9.185		2.808		0.986		0.961		0.325
Regional Issues		0.000		0.000		0.000		0.000		0.000
National Strategy/ Policy Impact		0.900		0.090		0.154		0.158		0.163
Total cost increase		68.058		29.563		28.671		30.437		31.906
Efficiency Gap		(29.312)		(14.609)		(13.343)		(14.726)		(15.802)

Annex B – 5 Year Capital Financial Plan

	2022/23	2023/24	2024/25	2025/26	2026/27
SOURCES OF FUNDING	£'m	£'m	£'m	£'m	£'m
Scottish Government General Allocation	6.389	6.389	6.389	6.389	6.389
Covid Allocations	0.600	1.000			
Return of Banked Funding	4.518		-1.000	1.000	
Indirect Capital Exp. Charged to Revenue	-1.300	-1.300	-1.300	-1.100	-0.600
Asset Sales Retained	0.150	1.048	1.730	0.000	0.000
Total Capital Resource Limit	10.357	7.137	5.819	6.289	5.789
PLANNED CAPITAL EXPENDITURE	£'m	£'m	£'m	£'m	£'m
Information Management & Technology	2.514	2.514	2.514	2.000	2.000
Medical Equipment	2.000	2.000	2.000	2.000	2.000
Facilities & Infrastructure	4.389	2.619	2.301	3.085	2.085
NHS Board	1.454	0.004	-0.996	-0.796	-0.296
Total Capital Expenditure	10.357	7.137	5.819	6.289	5.789
Balance	0.000	0.000	0.000	0.000	0.000
Memorandum - Forecast Property Sales	2022/23	2023/24	2024/25	2025/26	2026/27
Westbank Clinic	0.150				
Bellsdyke Land		1.048			
Barnton Street SITE			0.130		
Land at Graham Avenue, Larbert			0.100		
Land at Livlands, Stirling			1.500		
Total Forecast property Sales	0.150	1.048	1.730	0.000	0.000

FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

6.3 Code of Corporate Governance For Assurance

Executive Sponsor: Mrs Cathie Cowan, Chief Executive

Author: Ms Kerry Mackenzie, Head of Policy & Performance

Executive Summary

NHS Forth Valley's Code of Corporate Governance is based on the principles of the UK Corporate Governance Code. The main principle of the code is that every institution should be headed by an effective Board, which is collectively responsible for the success of the organisation. The Board's role is to provide leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed.

NHS Forth Valley's Code of Corporate Governance sets out the framework for our organisation and embraces governance of the NHS Board and associated committees.

Recommendation

The Forth Valley NHS Board is asked to: -

- **note** the amendments to the Code of Corporate Governance
- **note** the updated Terms of Reference within Section A - Standing Orders
- **note** further updates will be made to the Code of Corporate Governance as necessary to ensure it reflects current policy and guidance
- **approve** the Code of Corporate Governance ahead of presentation to the Board Assurance Committees

Key Issues to be Considered

The Code of Corporate Governance was initially presented to the NHS Board in September 2021. Following discussion and feedback a number of areas were reviewed and amended with the paper resubmitted to the November 2021 meeting of the NHS Board. It was noted that an annual review of the Code including the Assurance Committee Terms of Reference would be presented in March 2022.

Summary of amendments:

- In relation to Minutes, all Assurance Committee Terms of Reference now read, *Formal Minutes will be kept of proceedings and submitted for approval at the next meeting. Recognising the issue of the relative timing and scheduling of meetings, a summary of the key areas of business of the Committee will be presented to the next NHS Board Meeting to ensure NHS Board Members are aware of issues considered and decisions taken by the respective Committees.*
- Audit and Risk Committee Terms of Reference
 - Quorum changed from five members to two members.
 - Section 4.2.1 - expanded reference to Risk Management arrangements

- Internal Audit section 4.3.6 – addition of, *Non-Executive members will have the facility to regularly meet with Internal and External Auditors for private discussions.*
- Clinical Governance Committee Terms of Reference
 - Clinical Risk Management included in the purpose at section 1.
 - Membership increased from 2 Non-Executive Members of the NHS Board to 5 Non-Executive members.
 - Attendance – the Director of Human Resources will normally attend. This was previously the Deputy Director of Human Resources.
 - Quorum increased from two Non-Executive Directors to three.
 - Ethical Issues Sub-Committee – inclusion of, *the Sub-Committee delegates discussion to the Ethical Advisory Group which is a sub-group of the Clinical Governance Working Group.*
 - Explicit linkage to the Quality Strategy highlighted under responsibilities.
- Endowments Committee Terms of Reference
 - National Review of endowments underway with significant impact anticipated. Guidance awaited.
- Performance and Resources Committee Terms of Reference
 - Membership updated to reflect current membership of eight Non-Executive Directors, 1 of which should be the employee Director, 1 of which should be Chair of the Area Clinical Forum, and 3 of which should be a Local Authority member.
 - Attendance updated to include Director of Acute Services and Director of Facilities & Infrastructure, & Digital & eHealth Lead.
 - Quorum increased to three Non-Executive Members and three Executive Directors. This was previously two.
 - Digital Strategy included in the remit.
- Staff Governance Committee Terms of Reference
 - Membership updated to reflect current membership of 6 Non-Executive Members of the NHS Board one of whom must be the Employee Director, one of whom must be the Chair of the NHS Board, and 2 lay representatives from the Trade Unions and Professional Organisation nominated by the Area Partnership Forum.
- There are currently no changes to the Code of Conduct however a draft Model Code of Conduct for Health Boards has been developed. Agreement from Board Chairs is being sought. Thereafter, each NHS Board will be asked to officially approve the revised Code of Conduct ahead of seeking sign off from the Cabinet Secretary. The updated Code of Conduct will be included in the Code of Corporate Governance and published on the NHS Forth Valley website.
- No changes to the Standards of Business Conduct for NHS Staff.
- Fraud Standards have been updated ensuring linkage to Whistleblowing arrangements.
 - added a section, in accordance with the request from the Counter Fraud Services (CFS) Steering Group for Boards to make explicit in their SFIs, that CFS staff have right of access to any necessary information or material required in the course of progressing an investigation into fraud.
 - Update to key contacts
 - References to Family Health Service have been amended to Primary Care Services to reflect current terminology.
- No changes have been made to the Standing Financial Instructions.
- No changes have been made to the Risk Management section however note that the Risk Management Strategy has been reviewed with comments received from Internal Audit

colleagues. This review work was paused whilst recruitment to the post of Corporate Risk Manager was undertaken. Work to progress the strategy will continue once the successful candidate commences. It is anticipated that this will be towards the end of April 2022.

The Code of Corporate Governance will be kept under review and amended as necessary to ensure it reflects current policy and guidance. A full review and update will be undertaken in March 2023.

Financial Implications

There are no specific financial implications in respect of this paper.

Workforce Implications

There are no specific workforce implications in respect of this paper.

Risk Assessment

Good Corporate Governance will ensure that controls are in place that support the maintenance of a system of risk management for NHS Forth Valley.

Relevance to Strategic Priorities

Good governance is essential in addressing the challenges the public sector faces. The provision of high quality, safe, sustainable health and social care services depends on NHS Boards developing robust, accountable, and transparent corporate governance systems.

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity

Consultation Process

- NHS Forth Valley Finance colleagues
- Assurance Committee leads
- NHS Forth Valley Chief Executive's Office

Code of Corporate Governance

Version	Purpose/Change	Author	Date
1.0	Annual Review of Code of Corporate Governance	Cathie Cowan, Chief Executive Kerry Mackenzie, Head of Policy & Planning Jackie McEwan, Corporate Business Manager Sinead Hamill, Board Secretary	September 2021
2.0	Addition of amendments following review by NHS Board in September	Cathie Cowan, Chief Executive Kerry Mackenzie, Head of Policy & Planning	November 2021
3.0	Review of Assurance Committee Terms of Reference. Update to Fraud Policy	Kerry Mackenzie, Head of Policy & Planning	March 2022

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Section A How Business is Organised – Standing Orders	15
<p>This section explains how the business of Forth Valley NHS Board and its Committees is organised.</p> <ol style="list-style-type: none"> 1. Forth Valley NHS Board 2. Membership 3. Chairperson 4. Vice Chairperson 5. Resignation and Removal of members 6. Suspension and Disqualification 7. Proceedings 8. Conduct of Meeting 9. Declaration of interests, register of conflict and interest 10. Admission of public and press 11. Common seal and execution of documents 12. Appointment and function of committees 13. Decisions retained by Forth Valley NHS Board and Scheme of delegation 14. Scheme of delegation 15. Standing financial instructions <p>Annex A Suspension and disqualification</p> <p>Annex B Assurance Committee Terms of Reference</p> <p>Annex C Scheme of Decisions retained by Forth Valley NHS Board (Section D)</p> <p>Annex D Scheme of Delegation</p> <p>Standing Financial Instructions (Section E)</p>	
Section B Members Code of Conduct	62
<p>This section is for Members of Forth Valley NHS Board and its Committees and details how they should conduct themselves in undertaking their duties.</p> <ol style="list-style-type: none"> 1. Introduction to the Code of Conduct 2. Key Principles of the Code of Conduct 3. General Conduct 4. Registration of Interest 5. Declaration of Interest 6. Lobbying and Access to members of public bodies <p>Annex A Sanctions Available to The Standards Commission for Breach of The Code</p> <p>Annex B Definitions</p>	

Section C Standards of Business Conduct for NHS Staff

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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.

- 1. Introduction to the Standards of Business**
- 2. The Bribery Act 2010 – NHS Forth Valley’s Aims and Objectives**
- 3. The Bribery Act 2021 – Key Points**
- 4. Responsibilities of Staff**
- 5. Key Principles of Business Conduct**
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Section D The Fraud Standards

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This Section explains how staff must deal with suspected fraud, theft, and corruption (including bribery) and Forth Valley NHS Board’s response to a reported suspicion of fraud/theft and corruption

- 1. Fraud Policy**
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This section explains how staff will control the financial affairs of NHS Forth Valley and ensure proper standards of financial conduct.

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- 2. Responsibilities of the Chief Executive as Accountable Officer**
- 3. Allocations, Business Planning and Budgetary Control**
- 4. Health and Social Care Integration**
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6. Banking and Investments
7. Capital Investments, Private Financing, Fixed Asset Registers and Security of Assets
8. Purchasing of Supplies and Services
9. Income, Fees and Charges, Security of Cash and other Negotiable Instruments
10. Terms of Service and Payment of Directors and Staff
11. Payment of Accounts and Claims
12. Condemnations, Losses and Special Payments
13. Endowments and Trust Funds
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Section F Risk Management

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1. Introduction
2. Risk Architecture
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- Appendix A:** Glossary
- Appendix B:** Risk Assessment Matrix

Introduction

1. Code of Corporate Governance

The Code of Corporate Governance includes the following sections:

- Section A - How business is organised
- Section B - Members Code of Conduct
- Section C - Standards of Business Conduct for NHS Staff
- Section D - The Fraud Standards
- Section E - Standing Financial Instructions
- Section F - Risk Management

The Board keeps the Code of Corporate Governance under review and will undertake a comprehensive review annually.

2. Forth Valley NHS Board

Forth Valley NHS Board (the Board) is a strategic body, accountable to the Scottish Government Health and Social Care Directorate and to Scottish Ministers for the functions and performance of NHS Forth Valley. The Board consists of the Chair, Non-Executive and Executive Members, who are appointed by the Scottish Ministers.

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.

2.1 Overall Purpose

Effective NHS Boards articulate an ambition for their organisation whilst managing the risk contained within that ambition and demonstrating leadership by undertaking 3 key roles:

- Formulating strategy for the organisation, including the development annually of a Delivery Plan
- Ensuring commitment and accountability by holding the organisation (all staff) to account for performance and the delivery of both improvement in population health, individual experience of care whilst operating with a context of affordability and sustainability
- Shaping a positive culture (open, just and fair) for the Board and organisation

In summary our purpose is:

- as a Board is 'we aim to optimise health, optimise care and optimise value'

2.2 The Role of the Board

- To undertake comprehensive health needs and assessment for the population served.
- To develop strategies and action plans to reduce health inequalities and create and protect health and health equity, working closely with key partners.
- To establish a range of illness prevention, health improvement and health and care services that are designed to protect and improve the health status of the people of Forth Valley.

- To ensure that health services are designed, delivered, and evaluated in a manner that assures patient safety.
- To focus clearly on health outcomes and people's experience of NHS Forth Valley.
- To contribute to strategic planning and ensure delivery of integrated health and social care services.
- To be accountable for the scrutiny and performance of NHS Forth Valley as a whole.
- To involve the public and community planning partners in the design and delivery of healthcare services.
- To involve staff in the design, delivery and evaluation of services.
- To ensure that resources are allocated in manner that supports the delivery of strategic priorities and the achievement of agreed outcomes including national and logical targets.
- To ensure that best value principles are adhered to in delivering and commission sessions.

3. Corporate Governance

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

- Service delivery arrangements
- Structures and processes
- Risk management and internal control
- Standards of conduct

NHS Forth Valley 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

3.1 Corporate Objectives

Our Corporate Objectives are to:

- Plan for the future
- Improve the Health and Wellbeing of the people of Forth Valley whilst reducing health inequities
- Enhance our focus on safety and quality
- Value and develop our people
- Demonstrate best value using resources
- Promote and build integrated services locally and regionally
- Demonstrate behaviours that nurture and support transformational change across our health and care system

3.2 Function

The Functions of the Board are:

- Provision of strategic leadership and direction for the local health system as a whole.
- Resource allocation to address local priorities.
- Oversight of implementation of the Annual Operational Plan.
- Management of ensuring the performance of NHS Forth Valley, including risk management, quality assurance and improvement.
- Ensuring that there is a robust governance and accountability framework to monitor compliance with all necessary standards, targets, and outcomes.

4. Composition of the Board

The Board will consist of the following Directors appointed by the Minister:

Non-Executive Directors	Executive Directors
<ul style="list-style-type: none"> • Chair • 6 Non-Executive Lay Members (one of which is Whistleblowing Champion) • Chair - Area Clinical Forum • Employee Director • 3 Local Authority Elected Members - 1 each from Local Authority notably: Clackmannanshire, Falkirk, and Stirling 	<ul style="list-style-type: none"> • Chief Executive • Director of Finance • Director of Public Health and Strategic Planning • Medical Director • Nurse Director

5. Individuals Roles, Responsibilities and Accountabilities

	Chair	Chief executive	Non-executive director	Executive director
Formulate Strategy	Ensures board develops vision, strategies and clear objectives to deliver organisational purpose.	Leads strategy development process.	Brings independence, external skills and perspectives, and challenge to strategy development.	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant).
Ensure Accountability	Holds CE to account for delivery of strategy Ensures board committees that support accountability are properly constituted.	Leads the organization in the delivery of strategy. Establishes effective performance management arrangements and	Holds the executive to account for the delivery of strategy. Offers purposeful, constructive scrutiny and challenge. Chairs or participates	Leads implementation of strategy within functional areas.

		controls. Acts as Accountable Officer.	as member of key committees that support accountability.	
Shape Culture	Provides visible leadership in developing a positive culture for the organisation and ensures that this is reflected and modelled in their own and in the board's behaviour and decision making. Board culture: Leads and supports a constructive dynamic within the board, enabling contributions from all directors.	Provides visible leadership in developing a positive culture for the organisation and ensures that this is reflected in their own and the executive's behaviour and decision making.	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour. Provides a safe point of access to the board for whistle-blowers.	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour.
Context	Ensures all board members are well briefed on external context.	Ensures all board members are well briefed on external context.		
Intelligence	Ensures requirements for accurate, timely & clear information to board/ directors (and governors for FTs) are clear to executive.	Ensures provision of accurate, timely & clear information to board/ directors (and governors for FTs).	Satisfies themselves of the integrity of financial and quality intelligence.	Takes principal responsibility for providing accurate, timely and clear information to the board.
Engagement	Plays key role as an ambassador, and in building strong partnerships with: <ul style="list-style-type: none"> • Patients and public • Member and governors (FT) • Clinicians and Staff • Key institutional • Stakeholders • Regulators 	Plays key leadership role in effective communication and building strong partnerships with: <ul style="list-style-type: none"> • Patients and public • Member and governors (FT) • Clinicians and Staff • Key institutional • stakeholders • Regulators 	Ensures board acts in best interests of the public. Senior independent director is available to members and governors if there are unresolved concerns (FTs).	Leads on engagement with specific internal or external stakeholder groups.

6. Values

The Purpose, Role, Functions and Responsibilities of Forth Valley NHS Board and Board Members, will be delivered in a way which upholds the organisational values. NHS Forth Valley's values represent the care our patients can expect, and how this care should be delivered by our staff.

Our local values in NHS Forth Valley are:

- Be person centred
- Be respectful
- Have integrity
- Be ambitious
- Be supportive
- Be a committed team member

Our Values should be visible in everything we do and drive the improvement of our services.

NHS Forth Valley's values are closely aligned to the NHS Scotland's values, which are shared by all staff throughout Scotland:

- Care and Compassion
- Dignity and Respect
- Openness, Honesty and Responsibility
- Quality and Teamwork

Both sets of values underpin and support NHS Scotland's national quality ambitions: Person-centred; Safe; and Effective.

7. Conduct, Accountability, and Openness

Members of Forth Valley NHS Board (Executive and Non-Executive) 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
- Honest
- Respect

Understanding our 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. Managers are responsible for ensuring their staff understand their own responsibilities. The Code of Corporate Governance will be published on the Board's website and intranet.

Endowment Funds

The principles of this code of Corporate Governance apply equally to Member of Forth Valley NHS Board who have distinct legal responsibilities as Trustees of the Endowment Funds.

Advisory and Other Committees

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

Review

The Board will review the Code of Corporate Governance on an annual basis and will revise the Code to reflect any National or Local Changes which impact on the Board and its functions. The Board may, on its own or if directed by the Scottish Ministers, vary and revoke Standing Orders for the regulations of the procedures of business of the Board and of any Committee.

Feedback

NHS Forth Valley aims to continuously improve the services we deliver, and it is important that this Code remains relevant, we would therefore be happy to hear from you regarding new operational of statements or any other matter connected with the Code.

Comments and suggestions for improvement are most welcome and should be sent to:

Corporate Business Manager
NHS Forth Valley
Carseview House
Castle Business Park
Stirling
FK9 4SW

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 the interpretation and in addition:

Definition	Meaning
The Accountable Officer	Is the Chief Executive of NHS Forth Valley, who is responsible to the Scottish Parliament for the economical, efficient, and effective use of resources. The Chief Executive of NHS Forth Valley is also accountable to the Board for clinical, staff and financial governance, including controls assurance and risk management, and for delivery of other statutory requirements. This is a legal appointment made by the Principal Accountable Officer of the Scottish Government. (Public Finance and Accountability (Scotland) Act 2000 Memorandum to Accountable Officers for other Public Bodies).
The Act	The National Health Service (Scotland) Act 1978 as amended.
The 2001 Regulations	The Health Board's (Membership and Procedure) (Scotland) Regulations 2011.
The 1960 Act	The Public Bodies (Admission to Meetings) Act 1960 as amended.
Board Member	A person appointed as a Member of the Board by Scottish Ministers and who is not disqualified from membership.
Budget	Money proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Board.
Chair	The person appointed by the Scottish Ministers to lead the Board and to ensure that it successfully discharges its responsibility as a whole. The Chair of a Committee is responsible for fulfilling the duties of a Chair in relation to that Committee only.
Chief Executive	The Accountable Officer of NHS Forth Valley.
Committee	A Committee established by the Board and includes "Sub-Committee".
Committee Members	People formally appointed by the Board to sit on or to Chair specific committees.
Contract	Any arrangements including an NHS Contract.
Co-opted Member	An individual, not being a Member of the Board, who is appointed to serve on a Standing Committee, Special Committee, or Sub-Committee of the Board.
Community Planning Partners	Statutory Service providers, third and independent sector organisations with a stake in providing services and support to people in Forth Valley.

Integration Joint Board	The constitutional arrangements for the establishment of Integration Joint Boards are set out within Scottish Statutory Instrument 2014 No. 285 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.
Lay Member	An individual, not being an employee of the Board, who is appointed to serve on a Committee of the Board.
Meeting	A meeting of the Board or any Committee.
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within the Code of Corporate Governance.
Department of Health and Social Care	The Scottish Government and is its legal name.
SFIs	Standing Financial Instructions.
Vice Chair	The Non-Executive Member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

SECTION A

How Business is Organised - Standing Orders

Standing Orders for the Proceedings and Business of Forth Valley NHS Board

1. General

- 1.1. These Standing Orders for regulation of the conduct and proceedings of Forth Valley NHS Board, the common name for Forth Valley 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).

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

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

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

- 1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension, and disqualification of members in line with the above regulations. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.
- 1.3 Any statutory provision, regulation, or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.
- 1.4 Any one or more of these Standing Orders may be varied or revoked at a meeting of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment. The Board will annually review its Standing Orders.
- 1.5 Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a member from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

Board Members – Ethical Conduct

- 1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of the Forth Valley NHS Board 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 Date Approved: March 2021 Review Date: March 2022 3staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend his or her entry in the Register, he or she must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.
- 1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.
- 1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders and have regard to Section 5 of the Code of Conduct (Declaration of Interests).
- 1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.
- 1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations or cross-refer to where the information is published.
- 1.11 The Board's Corporate Business Manager shall provide a copy of these Standing Orders to all members of the Board on appointment. A copy shall also be held on the Board's website.

2. Chair

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

3. Vice Chair

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

- 3.2 The Vice Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice Chair is the process described at paragraph 3.1.
- 3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform his or her duties due to illness, absence from Scotland or for any other reason, then the Board's Corporate Business Manager 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 6 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 decide. 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 Lack of service of the notice on any member shall not affect the validity of a meeting.
- 4.8 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 and shall be placed on the Board's website. The meeting papers shall be placed on the Board's website directly following the meeting. 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, 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 committee, whether or not they are also members of the Board, e.g., stakeholder representative.
- 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. Items will be detailed on the Board meeting agenda noting the grounds for consideration in closed session. 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's Corporate Business Manager (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:

Standing Orders

- a) The establishment and terms of reference of all its committees, and appointment of committee members.
- b) Organisational Values.
- c) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
- d) 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).

- e) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
- f) Risk Management Policy.
- g) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
- h) Standing Financial Instructions and a Scheme of Delegation.
- i) 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).
- j) 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.
- k) The Board shall approve the content, format, and frequency of performance reporting to the Board.
- l) 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 and the Scheme of Delegation available on the NHS Board website.

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/boarddevelopment>)
- 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 include 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 Forth Valley NHS Board and is not to be counted when determining the committee's quorum.

ANNEX A: STANDING ORDERS SUSPENSION AND DISQUALIFICATION

- (1) Subject to paragraphs (2) and (3), a person shall be disqualified from being a Member, if-
- (a) they have, within the period of five years immediately preceding the proposed date of appointment, been convicted in the United Kingdom, the Channel Islands, the Isle of Man, or the Irish Republic of any offence in respect of which they have received a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.
 - (b) their estate has been sequestrated in Scotland or they have otherwise been adjudged bankrupt elsewhere than in Scotland, they have granted a trust deed for the benefit of their creditors or entered into any arrangement with their creditors, or a curator bonis or judicial factor has been appointed over their affairs.
 - (c) they have resigned or been removed or been dismissed, otherwise than by reason of redundancy, from any paid employment or office with a health service body.
 - (d) they are a person whose appointment as the chairperson, member or director of a health service body has been terminated other than by the expiration of their term of office.
 - (e) they are a chairperson, member, director, or employee of a health service body outwith the Forth Valley NHS Board area.
 - (f) they have had their name removed, by a direction under section 29 of the Act, from any list prepared under Part II of the Act and have not subsequently had their name included in such a list.
 - (g) they are a person whose name has been included in any list prepared under Part II of the Act, and whose name has been withdrawn from the list on their own application.
 - (h) they have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of the 1977 Act and have not subsequently had their name included in such a list.
 - (i) they are a person whose name has been included in any list prepared under Part II of the 1977 Act, and whose name has been withdrawn from the list on their own application.
 - (j) they are a person who is subject to a disqualification order under the Company Directors Disqualification Act 1986; or
 - (k) they are a person who has been removed from the position of trustee of a charity, whether by the court or by the Charity Commissioner.
- (2) For the purpose of paragraph (1):
- (a) the disqualification attaching to a person whose estate has been sequestrated shall cease if and when -

- (i) the sequestration of their estate is recalled or reduced; or
 - (ii) the sequestration is discharged.
 - (b) the disqualification attaching to a person by reason of their having been adjudged bankrupt shall cease if and when -
 - (i) the bankruptcy is annulled; or
 - (ii) they are discharged.
 - (c) the disqualification attaching to a person in relation to whose estate a judicial factor has been appointed shall cease if and when -
 - (i) that appointment is recalled; or
 - (ii) the judicial factor is discharged.
 - (d) the disqualification attaching to a person who has granted a trust deed or entered into an arrangement with their creditors shall cease if and when that person pays their creditors in full or on the expiry of five years from the date of their granting the deed or entering into the arrangement.
- (3) The Scottish Ministers may direct that in relation to any individual person or Board any disqualification so directed shall not apply in relation thereto.
- (4) For the purposes of paragraph (1)(a) the date of conviction shall be deemed to be the date on which the days of appeal expire without any appeal having been lodged, or if an appeal has been made, the date on which the appeal is finally disposed of or treated as having been abandoned.

ANNEX B: STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF FORTH VALLEY NHS BOARD

ASSURANCE COMMITTEE TERMS OF REFERENCE

- Audit and Risk Committee
- Clinical Governance Committee
- Clinical Governance Ethical Issues Sub-Committee
- Endowments Committee
- Performance and Resources Committee
- Pharmacy Practices Committee
- Remuneration Committee
- Staff Governance Committee

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

The purpose of the Audit Committee is to ensure that NHS Board activities including Patients Private Funds and Endowment Funds are:

- within the law and regulations governing the NHS.
- that an effective system of internal control is maintained to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided, and reliable financial information produced and that value for money is continuously sought.

2. COMPOSITION

2.1 Membership

The membership of the Committee shall consist of five Non-Executive Members of the NHS Board. The Chair of NHS Forth Valley and Executive NHS Board Members are not eligible for Membership – the Chief Executive and Director of Finance will be in attendance.

2.2 Appointment of Chairperson and Vice Chair

The Chairperson of the Committee (Non-Executive) shall be appointed at a full business meeting of Forth Valley NHS Board in accordance with Standing Orders. The Committee will appoint a Vice Chair in addition to the Chair. The Chair shall preside at every meeting of the Committee. The Vice Chair shall preside if the Chair is absent.

2.3 Attendance

The Chief Executive and the Director of Finance of NHS Forth Valley, the Chief Internal Auditor and the Statutory External Auditor shall normally attend meetings. The Committee can request the attendance of any officer of NHS Forth Valley. All NHS Board Members shall have the right of attendance and have access to papers, except where the Committee resolves otherwise.

3. MEETINGS

3.1 Frequency

Meetings of the Committee will be timetabled annually to coincide with the important events of the year and before important decisions are made.

Meetings will be held at a minimum of four times per annum. This timetable should also assist with scheduling key items of business to be discussed at each meeting.

3.2 Agenda and Papers

The Agenda and supporting papers will be sent out at least three clear days in advance of the meetings. All papers will clearly state the agenda reference, the author, the purpose of the paper together with the action the Committee is asked to consider.

3.3 Quorum

No business shall be transacted unless a minimum of two Audit and Risk Committee Members are present.

3.4 Minutes

Formal Minutes will be kept of proceedings and submitted for approval at the next meeting. Recognising the issue of the relative timing and scheduling of meetings, a summary of the key areas of business of the Audit and Risk Committee will be presented to the next NHS Board Meeting to ensure NHS Board Members are aware of issues considered and decisions taken by the respective Committees.

The draft Minutes will be cleared by the Chair of the Committee and the nominated Lead Director prior to distribution.

3.5 Other

If necessary, meetings of the Committee shall be convened and attended exclusively by Members of the Committee and/or the External Auditor or Internal Auditor.

The Chief Internal Auditor and a representative from External Audit will have free and confidential access to the Chair of the Audit and Risk Committee.

4. REMIT

4.1 Objectives

The main objectives of the Audit and Risk Committee are to ensure that NHS Forth Valley acts within the law, regulations, and code of conduct applicable to it and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee are in accordance with the Public Sector Internal Audit Standards and the Scottish Government Audit Committee Handbook. The Audit and Risk Committee will also periodically review its own effectiveness and report the results of that review to the Board and Accountable Officer.

4.2 Internal Control and Corporate Governance

4.2.1 To evaluate the framework of internal control and corporate governance comprising the following components:

- Control environment
- Review and assess the adequacy of the organisations risk management arrangements, systems and processes
- approve the annual risk management reports on effectiveness, adequacy and robustness of the risk management system

- Decision-making processes
- Information and communication
- Monitoring and corrective action
- Anti-fraud policies, whistle-blowing processes, and arrangements for special investigations

4.2.2 To review the system of internal financial control which includes:

- The safeguarding of assets against unauthorised use and disposition.
- Maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication.

4.2.3 To ensure the NHS Board's activities are within the law and regulations governing the NHS.

4.2.4 To review and recommend approval to the NHS Board of the Risk Management Strategy.

4.2.5 To present an annual assurance statement on the above to the NHS Board to support the Governance Statement.

4.2.6 To take account of the implications of publications detailing best audit practice.

4.2.7 To take account of recommendations contained in the relevant reports of the Auditor General and the Scottish Parliament.

4.3 Internal Audit

4.3.1 To influence, review and approve the Internal Audit Strategic and Annual Plan.

4.3.2 To monitor audit progress and review audit reports.

4.3.3 To monitor the management action taken in response to the audit recommendations through an agreed follow-up mechanism.

4.3.4 To consider the Chief Internal Auditor's annual report and assurance statement.

4.3.5 To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency, and performance measures.

4.3.6 To ensure there is direct contact between the Audit and Risk Committee and Internal Audit and the opportunity is given for discussions with the Chief Internal Auditor as required without the presence of the Executive Directors. The Chief Internal Auditor must have appropriate access to both the Chief Executive and the Chair of the Audit and Risk Committee. Non-Executive members will have the facility to regularly meet with Internal and External Auditors for private discussions.

4.3.7 To review the terms of reference and appointment of the Internal Auditors.

4.4 External Audit

4.4.1 To review the Audit Strategy and Plan, including the Performance Audit Programme.

4.4.2 To consider all statutory audit material, in particular:

- Audit Reports (including Performance Audit Studies)
- Annual Reports
- Management Letters

relating to the certification of the NHS Board.

4.4.3 To monitor management action taken in response to all External Audit recommendations including Performance Audit Studies following consideration by the relevant Committee.

4.4.4 To hold meetings with the External Auditors at least once per year without the presence of the Executive Directors.

4.4.5 To review the extent of co-operation between External and Internal Audit.

4.4.6 Annually appraise the performance of the External Auditors.

4.4.7 To note the appointment and remuneration of External Auditors and to examine any reason for the resignation or dismissal of the Auditors.

4.5 Standing Orders and Standing Financial Instructions

4.5.1 To review changes to the Standing Orders and Standing Financial Instructions.

4.5.2 To examine the circumstances associated with each occasion when Standing Orders are waived or suspended.

4.5.3 To review the Scheme of Delegation.

4.6 Annual Accounts

4.6.1 To review annually (and approve) any changes in accounting policy.

4.6.2 To review schedule of losses and compensation payments.

4.6.3 To review and recommend approval to the NHS Board of the Annual Accounts.

4.6.4 To report in the Directors Report on the roles and responsibilities of the Audit Committee and actions taken to discharge those.

4.6.5 To review and recommend approval to the NHS Board of the Patients Funds Annual Accounts.

4.7 Receive reports from the FHS (Family Health Service) Performance Review / Reference Group which is responsible for dealing with Primary Care contractor issues and alleged breaches of terms of reference.

5. OTHER

- 5.1** The Committee has a duty to review its own performance, effectiveness, and terms of reference on an annual basis.
- 5.2** The Committee shall monitor the mechanism to keep up to date with changes to topical laws and regulations.
- 5.3** The Chairperson shall submit an Annual Report of the work of the Committee to the NHS Board.
- 5.4** The Committee is authorised to obtain outside legal or other professional advice it considers necessary.

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

The purpose of the Clinical Governance Committee is to provide the NHS Board with

- Systems Assurance – to ensure effective Clinical Governance is in place and effective throughout the local NHS system and services and is effective in services that are commissioned from independent providers and other partner agencies.
- Public Health Governance – to ensure that the principles and standards of clinical governance are applied to the health improvement and health protection activities of the NHS Board.
- Clinical Risk Management – assurance that an appropriate approach is in place to deal with clinical risk management across the system, working within the NHS Forth Valley Risk Management Strategy

2. COMPOSITION

2.1 Membership

The Membership of the Committee shall consist of:

- Five Non-Executive Members of the NHS Board
- Chair of Area Clinical Forum
- Two Members of the NHS Forth Valley Public Involvement Network

2.2 Appointment of Chairperson and Vice Chair

The Chairperson of the Committee (Non-Executive) shall be appointed at a full business meeting of Forth Valley NHS Board in accordance with Standing Orders. The Committee will appoint a Vice Chair in addition to the Chair. The Chair shall preside at every meeting of the Committee. The Vice Chair shall preside if the Chair is absent.

2.3 Attendance

The Chief Executive of NHS Forth Valley, the Medical Director, the Nurse Director, the Director of Public Health & Strategic Planning, and the Director of Pharmacy will normally attend. Additionally, the Director of Human Resources, the Head of Clinical Governance and the Infection Control Manager shall also normally attend. The Committee can request the attendance of any officer or family practitioner of NHS Forth Valley at its meetings.

All NHS Board Members shall have the right of attendance and have access to papers except where the Committee resolves otherwise.

3. MEETINGS

3.1 Frequency

Meetings of the Committee will be timetabled annually. This schedule should also identify the key items of business to be discussed at each meeting.

The Committee shall meet as necessary to fulfil its remit and Meetings will be held at a minimum of once in every quarter.

3.2 Agenda and Papers

The Agenda and supporting papers will be sent out at least three clear days in advance of the meetings. All papers will clearly state the agenda reference, the author, the purpose of the paper together with the action the Committee is asked to consider.

3.3 Quorum

No business shall be transacted unless a minimum of three Non-Executive Members are present.

3.4 Minutes

Formal Minutes will be kept of proceedings and submitted for approval at the next meeting. Recognising the issue of relative timing and scheduling of meetings, a summary of the key areas of business of the Clinical Governance Committee will be presented to the next Board Meeting to ensure NHS Board Members are aware of issues considered and decisions taken by the respective Committees.

The draft Minutes will be cleared by the Chair of the Committee and the nominated lead Director prior to distribution. Given the potential for minutes to contain In Confidence Information, these Minutes may require to be considered in a closed session of the NHS Board.

3.5 Other

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

3.6 Clinical Governance Working Group

Minutes of the Clinical Governance Working Group will be presented to the Clinical Governance Committee. Recognising the issue of relative timing and scheduling of meetings, a summary of the key areas of business of the Clinical Governance Working Group will be presented to the next Clinical Governance Committee. The Clinical Governance Working Group reports to the Clinical Governance Committee.

3.7 Ethical Issues Sub-Committee

Minutes (or draft Minutes) of the Ethical Issues Sub-Committee will be presented to the Clinical Governance Committee following the meeting of the Sub-Committee. The Committee meets on an ad hoc basis as required. The Sub-Committee reports to the Clinical Governance Committee. The Sub-Committee delegates discussion to the Ethical Advisory Group which is a sub-group of the Clinical Governance Working Group.

3.8 Organ Donation Sub-Committee

Minutes (or draft Minutes) of the Organ Donation Sub-Committee will be presented to the next Clinical Governance Committee. The Sub-Committee reports to the Clinical Governance Committee.

4. REMIT

4.1 Objectives

The main objectives of the Clinical Governance Committee are to provide:

- Systems Assurance
- Public Health Governance
- Clinical Risk Management

4.2 Responsibilities

The responsibilities of the Committee shall be to: -

- 4.2.1 Ensure that all elements of the Clinical Governance Framework within the Quality Strategy are being adequately taken forward and coordinated within acute care, primary care and community care.
- 4.2.2 Ensure that all elements of the Clinical Governance Framework within the Quality Strategy are implemented effectively and efficiently across the system.
- 4.2.3 Ensure that appropriate standards of clinical governance are being applied to the health improvement and health protection activities of the Board.
- 4.2.4 Ensure that follow-up action is taken in relation to external reviews to provide assurance that the quality of services is being improved.
- 4.2.5 Promote positive complaints handling, advocacy and feedback including learning from adverse events, near misses and whistleblowing cases.
- 4.2.6 Ensure review of clinical governance objectives bi-annually to gain assurance across the whole NHS system with appropriate monitoring and action planning.
- 4.2.7 Ensure systems dealing with revalidation/fitness to practice are in place.

- 4.2.8 Review performance in management of clinical and population-based risk and delivery of services, including emergency planning and service continuity planning.
- 4.2.9 Receive regular reports that allow the Committee to assure the Board on key clinical priorities within a clear forward plan.
- 4.2.10 Receive reports from the, NHS Forth Valley Area Prevention & Control of Infection Committee, and Child Protection Action Group Quarterly Report.

5. OTHER

- 5.1 The Committee has a duty to review its own performance, effectiveness, including running costs and terms of reference on an annual basis.
- 5.2 The Chairman shall submit an Annual Report on the work of the Committee to the NHS Board.
- 5.3 The Committee is authorised to obtain professional advice it considers necessary.

CLINICAL GOVERNANCE ETHICAL ISSUES SUB-COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

The Ethical Issues Sub-Committee will ensure that ethical issues are given due consideration appropriate to an NHS provider of healthcare.

2. COMPOSITION

2.1 Membership

The membership of the Committee shall consist of:

- Chair of the Forth Valley Clinical Governance Committee
- Non-Executive Director of NHS Forth Valley
- Medical Director
- Head of Spiritual Care Services

2.2 Appointment of Chairperson

The Chairperson of the Committee (Non-Executive) shall be appointed at a full business meeting of the Clinical Governance Committee. The Committee will appoint a Vice Chair in addition to the Chair. The Chair shall preside at every meeting of the Committee. The Vice Chair shall preside if the Chair is absent.

2.3 Attendance

The Committee can obtain professional advice required and request the attendance of any officer of NHS Forth Valley to attend meetings.

All NHS Board Members shall have the right of attendance and have access to papers except where the Committee resolves otherwise.

3. MEETINGS

3.1 Frequency

The Committee shall meet as appropriate to fulfil its remit. Meetings will be held as necessary where there is business to consider.

3.2 Agenda and Papers

The Agenda and supporting papers will be sent out at least three clear days in advance of the meetings. All papers will clearly state the agenda reference, the author, the purpose of the paper together with the action the Committee are asked to consider.

3.3 Quorum

No business shall be transacted unless a minimum of two Committee Members are present.

3.4 Minutes

Formal Minutes will be kept of proceedings and submitted for approval at the next meeting, recognising the issue of relative timing of meetings. Minutes of the Ethical Issues Sub-Committee will be presented in draft form to the next Clinical Governance Committee meeting to ensure Clinical Governance Committee Members are aware of issues considered and decisions taken.

The draft Minute will be cleared by the Chair of the Committee and the nominated lead Executive prior to distribution.

3.5 Other

If necessary, meetings of the Committee shall be convened and attended exclusively by Members of the Committee.

4. REMIT

4.1 Objectives

The main objectives of the Ethical Issues Sub-Committee are to ensure that the purpose is met.

To ensure the purpose is met, the group is responsible for the following:

- To consider in detail all issues remitted and bring forward advice, judgements, and recommendations to the Clinical Governance Committee, which maintain integrity a highest level of public confidence in NHS Forth Valley.
- To ensure issues referred are competent having been through an appropriate referral process
- To determine if the issue is subject to legal process or whether there is an indication it may be subject to such a process, in which case any consideration by the Committee should be suspended.
- To examine and address education and training needs of members and others asked to attend.
- To consider if other reasonable means of resolving the issue have been exhausted and refer the issue to an alternative process where this is not the case.
- To, where necessary, clarify the “question” being asked together with the options and their potential implications and impacts.
- To seek all reasonable opinion and evidence to allow informed discussion.
- To be familiar with any significant legal or regulatory issues that may relate to the matter in question; this includes “case studies” and conclusions reached by others on similar matters.
- To analyse the issue using any suitable or relevant methodologies such as risk management
- To provide reports to the Clinical Governance Committee that clearly set out the issues, analysis undertaken and recommendations.

5. OTHER

- 5.1** The Committee has a duty to review its own performance, effectiveness, including running costs and Terms of Reference on an annual basis.
- 5.2** Reports will conform to national and NHS Forth Valley Information Governance standards and should not divulge any personal information without consent.

ENDOWMENTS COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

The purpose of the Endowments Committee is to ensure that endowment funds held in trust comply with the relevant laws and regulations and that an effective system of financial control is in place. In so far as they are able, the Committee would manage the Endowments Funds in accordance with the wishes of donors.

2. COMPOSITION

2.1 Trustees

All Members of the Forth Valley NHS Board shall be Members of the Endowment Fund.

2.2 Membership of Endowments Committee

The membership of the Committee shall consist of all Members of Forth Valley NHS Board.

It is expected that as a matter of routine three Non-Executive Members, the Chief Executive and the Director of Finance shall attend meetings.

2.3 Appointment of Chairperson

The Chairperson of the Committee (Non-Executive) shall be appointed at a full business meeting of Forth Valley NHS Board in accordance with Standing Orders. The Committee will appoint a Vice Chair in addition to the Chair. The Chair shall preside at every meeting of the Committee. The Vice Chair shall preside if the Chair is absent.

2.4 Attendance

The Lead Director for NHS Forth Valley Endowment Funds shall normally attend meetings. The Endowment Fund's Investment Advisors shall attend as required but at least annually. The appointed Endowment Auditors shall attend as required.

The Committee can request the attendance of any officer of NHS Forth Valley.

All Forth Valley NHS Board Members shall have access to the papers of the Committee.

3. MEETINGS

3.1 Frequency of Meetings

Meetings of the Committee will be timetabled annually. This schedule should also identify the key items of business to be discussed at each meeting.

The Committee shall meet as necessary to fulfil its remit and meetings will be held at least four times per year of which one meeting will be held to review the audited Annual Accounts and associated year-end reports.

3.2 Agenda and Papers

The Agenda and supporting papers will be sent out at least three clear days in advance of the meetings. All papers will clearly state the agenda reference, the author, the purpose of the paper, together with the action the Committee are asked to consider.

3.3 Quorum

No business shall be transacted unless a minimum of three Endowment Committee Members are present.

3.4 Minutes

Formal Minutes will be kept of proceedings and submitted for approval at the next meeting. Recognising the issue of relative timing and scheduling of meetings, a summary of the key areas of business of the Endowments Committee will be presented to the next Forth Valley NHS Board Meeting. The draft Minutes will be cleared by the Chair of the Committee and the nominated Lead Director.

3.5 Bursary Committee

The Bursary Committee reports to the Endowment Committee. Recognising the issue of relative timing and scheduling of meetings, Minutes (or draft Minutes) of the Bursary Committee will be presented to the next Endowment Committee.

4. REMIT

The main objectives of the Endowments Committee are:

- 4.1 To ensure that financial statements comply with the Charities and Trustee Investment (Scotland) Act 2005, Regulation 8 of the Charities Accounts (Scotland) Regulations 2006, United Kingdom Generally Accepted Accounting Practice, and appropriate NHS legislation.
- 4.2 To accept hold and administer legacies, donations and grants that may be used for purposes relating to Health Service functions or to research.
- 4.3 To appoint Investment Advisors to ensure best possible investment advice is available to invest in the best interests of the Fund. The Advisors should be appropriately regulated by the Financial Conduct Authority.
- 4.4 To monitor investment performance and agree distribution of investment income.
- 4.5 To consider recommendations for use of funds and to approve a Scheme of Delegation for Endowment Funds.

- 4.6 To approve an annual budget for unrestricted funds against plan and monitor expenditure of funds.
- 4.7 To review the system of internal control including evaluating the control environment and decision-making process. To receive Internal Audit Reports in respect of Endowment Funds.
- 4.8 To appoint the External Auditor for the Endowment Fund and to review the Management Letter to the Annual Accounts.
- 4.9 To adopt the audited Annual Accounts and to review the Endowment Fund Annual Report.

5. OTHER

- 5.1 The Committee has a duty to review its own performance, effectiveness including running costs and Terms of Reference on an annual basis.
- 5.2 The Chairperson shall submit an Annual Report of the work of the Committee to Forth Valley NHS Board.
- 5.3 The Committee is authorised to obtain professional advice it considers necessary.
- 5.4 The Committee should ensure compliance with the requirements of the Office of the Scottish Charity Regulator including the submission of an Annual Monitoring Return.

PERFORMANCE AND RESOURCES COMMITTEE

TERMS OF REFERENCE

1. Purpose

The purpose of the Performance and Resources Committee is:

- To scrutinise, on behalf of the Board, all financial and operational performance focusing on strategic planning, organisational priorities and ensuring that corrective actions are taken as required and improvements in performance acknowledged.
- To oversee the ongoing development of a performance management culture in the organisation where performance management is seen as part of the day job striving for excellence and focussing on improvement in all aspects of NHS Board business.
- Ensure the production of an Annual Plan, incorporating the Board's Financial Plan/Capital Plan/AOP and setting out the overall direction for the year for Board approval. The Committee will also ensure actions are in place to support the delivery of the plan acknowledging partnership delivery plans.
- Ensure NHS Forth Valley delivers its statutory obligation to comply with information governance and General Data Protection Regulation (GDPR). Maintain an overview of the work to deliver improvements in Information Governance ensuring appropriate prioritisation of this work.

2. Composition

2.1 Membership

The membership of the Performance and Resource Committee shall consist of:

- 8 Non-Executive Directors of the Board - 1 of which should be the employee Director, 1 of which should be Chair of the Area Clinical Forum, and 3 of which should be a Local Authority member
- Chief Executive
- Director of Finance
- Medical Director
- Director of Nursing
- Director of Human Resources
- Director of Public Health and Strategic Planning

2.2 Appointment of Chairperson

The Chairperson of the Performance and Resource Committee (Non-Executive) shall be appointed at a full business meeting of Forth Valley NHS Board in accordance with Standing Orders. The Committee will appoint a Vice Chair in addition to the Chair. The Chair shall preside at every meeting of the Committee. The Vice Chair shall preside if the Chair is absent.

2.3 Attendance

The Director of Acute Services, Director of Facilities & Infrastructure, & Digital & eHealth Lead, Head of Communications and the Head of Policy & Performance shall normally attend meetings.

The Committee can request the attendance of any officer of NHS Forth Valley at its meetings.

All NHS Board Members shall have the right of attendance and have access to papers except where the Committee resolves otherwise.

The Committee shall have the right to invite, as required, external experts to attend meetings.

3. Meetings

3.1 Frequency

Meetings of the Performance and Resource Committee will be timetabled bimonthly on the month opposite to the NHS Board meeting. The meeting schedule should also identify the key items of business to be discussed at each meeting.

The Performance and Resource Committee shall meet as necessary to fulfil its remit and meetings will be held at a minimum of bimonthly.

3.2 Agenda and Papers

The Agenda and supporting papers will be sent out at least three clear days in advance of the meetings. All papers will clearly state the agenda reference, the author, the purpose of the papers together with the action the Performance and Resource Committee is asked to consider.

3.3 Quorum

No business shall be transacted unless a minimum of three non-Executive Members and three Executive Directors are present.

3.4 Minutes

Formal Minutes will be kept of proceedings and submitted for approval at the next meeting.

Recognising the issue of relative timing and scheduling of meetings, a summary of the key areas of business of the Performance and Resource Committee will be presented to the next Board Meeting to ensure NHS Board members are aware of issues considered and decisions taken.

The draft Minutes will be cleared by the Chair of the Performance and Resource Committee and the nominated Lead Director prior to distribution. Given the potential for Minutes to contain In Confidence information, these Minutes may require to be considered in a closed session of the NHS Board.

4. Remit

The main objectives of the Performance and Resources Committee shall be:

4.1 Corporate Planning

- 4.1.1 Ensure the production of an Annual Operational Plan, incorporating the Board's Financial Plan/Capital Plan, setting out the overall direction for the year for Board approval.
- 4.1.2 Ensure actions are in place to support delivery of the Annual Operational Plan.
- 4.1.3 Monitor progress against the Annual Operational Plan, ensuring delivery against plan is achieved.
- 4.1.4 Oversee Community Planning Partnership activities and receive routine reports.
- 4.1.5 Ensure appropriate focus on strategic priorities and core objectives.

4.2 Performance and Risk

- 4.2.1 Support the development of a performance culture within NHS Forth Valley which will drive continuous quality improvement.
- 4.2.2 Approve the Board Performance Management Framework.
- 4.2.3 Review the Board's overall performance, strategic policy, and planning objectives, Forth Valley Quality Programme and ensure mechanisms are in place to promote best value, improved efficiency, and effectiveness.
- 4.2.4 Ensure 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 the full Board.
- 4.2.5 Adopt a risk-based approach to performance through routine review of the Balanced Scorecard, focussing on areas of corporate concern identified as requiring an additional strategic and collective approach to ensure delivery against performance targets.
- 4.2.6 Maintain an overview of the Corporate Risk Register reviewing risk appetite and agreeing appropriate escalation to the Board.

4.3 Finance and Efficiency

- 4.3.1 Review Financial Performance, focussing on areas of corporate concern which may require corporate decision making to enable delivery against plan.
- 4.3.2 Review the Board's savings plans to ensure that these deliver as required to support the Board's financial plan.
- 4.3.3 Review the Board's performance in relation to internal and external reports including benchmarking and efficiency indicators and to support opportunities for improving the Board's performance.
- 4.3.4 Maintain overview of IJB budget process and financial performance.

4.4 Property and Asset Management

- 4.4.1 Ensure the Property and Asset Management Strategy is developed, and the procedures are in place to ensure that it is maintained, reviewed, and remains deliverable.
- 4.4.2 Review all proposed property acquisitions and disposals in accordance with the NHS Property Transactions Handbook ensuring that due process has been followed to permit Board approval to proceed.
- 4.4.3 Approve Change Control notifications exceeding £20,000 (recurring) for the Board's PFI facilities.

4.5 Capital Projects

- 4.5.1 Review overall development of major schemes including capital investment business cases and consider the implications of time slippage and / or cost overrun. Instruct and review the outcome of the post project evaluation.
- 4.5.2 Review reports on significant capital projects.
- 4.5.3 Review compliance with relevant legislation and requirements of the Scottish Capital Investment Manual (SCIM).
- 4.5.4 Review periodically policies relating to capital projects and major equipment.

4.6 Information Governance

- 4.6.1 Ensure NHS Forth valley delivers its statutory obligation to comply with information governance and General Data Protection Regulation (GDPR).
- 4.6.2 Maintain an overview of the work to deliver improvements in Information Governance ensuring appropriate prioritisation of this work.

4.7 Digital strategy

- 4.7.1 Monitor delivery of the Digital and eHealth Plan.

5. OTHER

- 5.1 The Performance and Resource Committee has a duty to review its own performance and effectiveness including running costs and terms of reference on an annual basis.
- 5.2 The Performance and Resources Committee is authorised to obtain professional advice if it considers necessary.
- 5.3 The Chairperson shall submit an Annual Report of the work of the Performance and Resources Committee to the Board.

PHARMACY PRACTICES COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

- 1.1** The Committee shall be known as the Pharmacy Practices Committee and shall consider, determine and approve/reject applications for inclusion in the Pharmaceutical List in accordance with the NHS (Pharmaceutical Services) (Scotland) Regulations 2009 and the NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 (SSI 2011 No. 32) and 2014 (SSI 2014 No. 148).
- 1.2** The Committee shall, within 10 working days of taking its decision, give written notification of it to the Board with reasons for that decision.

2. COMPOSITION

2.1 Membership

The Pharmacy Practices Committee is appointed by the Board and shall consist of seven (unless the Application is for premises in a neighbourhood or an adjacent neighbourhood to a controlled locality, in which case an additional member will be appointed by the Board from persons nominated by the Area Medical Committees).

Members of whom:

- 2.1.1** One (Chair) shall be a Non-Executive Member of the Board appointed as Chair of the Pharmacy Practices Committee and shall not be nor have previously been, a Doctor, Dentist, Ophthalmic Optician or Pharmacist or an employee of a Doctor, Dentist, Ophthalmic Optician or Pharmacist.
- 2.1.2** Three shall be Pharmacists of whom:
- 2.1.2.1** One shall be a Pharmacist whose name is not included in a Pharmaceutical List and who is not an employee of a person whose name is so listed and who shall be appointed from a list of persons nominated by the Area Pharmaceutical Committee.
- 2.1.2.2** Two shall be Pharmacists whose names are either included on a Pharmaceutical List or are employees of a person whose name is on such a list and shall be appointed from a list of persons nominated by the Area Pharmaceutical Committee.
- 2.1.3** Three shall be Lay Persons appointed by NHS Forth Valley, other than from members of the Board, and shall not be nor have previously been a Doctor, Dentist, Ophthalmic Optician or Pharmacist or an employee of person who is a Doctor, Dentist, Ophthalmic Optician or Pharmacist.
- 2.1.4** In circumstances where the premises that are the subject of the Application are located in the same neighbourhood as a controlled locality the Pharmacy Practices Committee shall have an additional member appointed by the Board from persons nominated by the Area Medical Committee.

2.2 Appointment of Deputies

The Board shall also appoint deputies including, as the case may be for 2.1.4 for each Committee Member using the same criteria as set out in 2.1.

2.3 Eligibility

The Board shall ensure in appointing Members and Deputies to the Pharmacy Practices Committee that the eligibility criterion set out in the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 2009 the NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and in accordance with the provision of The Health Act 1999 are met.

If nominations are not made available before such a date as the Board may determine, the Board may appoint as a member a person who satisfies the appropriate criteria specified in 2.1 to 2.1.4.

2.4 Review

Membership shall be reviewed annually.

2.5 Attendance

The Board may appoint an independent legal assessor to attend to provide legal and technical advice during the hearing.

A person shall attend for the purpose of taking an accurate note of the Pharmacy Practices Committee meeting.

3. MEETINGS

3.1 The Pharmacy Practices Committee shall meet as necessary to fulfil its remit.

3.2 The agenda and supporting papers will be sent at least five days before the date of the meeting. In any case where oral representations are being heard, at least 7 days' notice of the date fixed for the meeting shall be given to all parties.

3.3 Quorum

No business will be conducted at the meeting of the Pharmacy Practices Committee unless five Members or deputies are present of whom:

3.3.1 one shall be the Chair of the Committee or deputy Chair.

3.3.2 one shall be a non-contractor Pharmacist in accordance with 2.1.2.1 or deputy.

3.3.3 one shall be a contractor Pharmacist in accordance with 2.1.2.1 or deputy.

3.3.4 two shall be Lay Persons in accordance with 2.1.3 or deputy.

3.3.5 In circumstances where the premises that are the subject of the Application are in the same neighbourhood as a controlled locality the Pharmacy Practices Committee shall have an additional member appointed by the Board from persons nominated by the Area Medical Committee.

3.4 Formal minutes will be kept of the proceedings of the Committee and approved by Members or deputies in accordance with 3.3, with the decision and the reasons for that decision reported to the Board. A copy of the Minutes of the NHS Forth Valley Pharmacy Practices Committee will be submitted to the NHS Board for noting.

3.5 Each application submitted to the Pharmacy Practices Committee under Regulation 5 (10) shall be discussed by all Members present at the meeting but shall be determined by the following Members (or their deputies) after the Non-Contractor and Contractor Pharmacists appointed by the Pharmacy Practices Committee and, if present, the member nominated by the Area Medical Committee, have withdrawn.

3.5.1 Lay Persons in accordance with 2.1.3.

3.6 The Chair or deputy Chair shall not be entitled to vote in respect of a determination of an application submitted under Regulation 5 (10) but in the case of an equality of votes under 3.5 shall have a casting vote.

3.7 In the case of all other matters considered under Regulation 5(10) except in respect of an application submitted under Regulation 5(10) all Members of the Committee present shall determine the matter.

3.8 In the case of urgent matters the Chair, or in their absence, the deputy Chair shall be empowered by the Committee to determine matters within the remit of the Committee with the exception of applications submitted under Regulation 5(10) in circumstances where it is necessary that, as a matter of urgency, a decision should be reached between scheduled meetings of the Committee.

3.9 Any decision taken under 3.8 shall be reported to the next meeting of the Committee for endorsement.

4. REMIT

4.1 The Committee shall determine and approve/reject applications for inclusion in the Pharmaceutical List as defined in terms of Regulation 5(10) and paragraph 3 of schedule 3 of the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 2009, the National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and in accordance with The Health Act 1999.

4.2 The Committee shall also be empowered to exercise other functions as are delegated to it by Forth Valley NHS Board under the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 2009, the National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and in accordance with The Health Act 1999 to the extent that those functions are not delegated to an Officer under the Scheme of Delegation.

4.3 Any Officer with delegated authority in respect of the provisions of the General Pharmaceutical Services under Part II of the National Health Service (Scotland) Act 1978, may refer to the Committee for determination of any matter within the Officer's delegated authority either as a matter of policy or in respect of a specific issue and the Committee shall be authorised to determine such matters.

4.4 In exercising and considering all applications submitted to it, the Committee shall have regard to the provisions of the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 2009, the National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 and 2014 (SSI 2014 No. 148) and The Health Act 1999 with particular reference to:

4.4.1 consultation with interested parties, appropriate members of the public; and

4.4.2 criterion for the granting of new pharmaceutical contracts.

5. AUTHORITY

5.1 The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

5.2 The Committee has a duty to review its own performance, effectiveness including running costs and terms of reference on an annual basis.

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. Role of the Committee

- 1.1 The main function of the Remuneration Committee is to ensure application and implementation of fair and equitable pay systems on behalf of the NHS Board, as determined by Ministers and Scottish Government. The Committee oversees the remuneration arrangements for Executive Directors and Senior Managers (on Executive pay grades) and Consultants of the NHS Board whilst also discharging specific responsibilities on behalf of the NHS Board as an employing organisation. The Remuneration Committee provides assurance that systems and procedures are in place to manage the responsibilities within its remit by providing an Annual Report of its work to the NHS Board.

2. Composition of the Committee

2.1 Membership

The Committee membership will comprise:

- the Non-Executive Chair
- the Non-Executive Board Vice Chair
- the Non-Executive Employee Director
- the Non-Executive Chair of the Audit & Risk Committee
- the Non-Executive Chair of the Clinical Governance Committee
- the Non-Executive Chair of the Staff Governance Committee
- the Non-Executive Chair of the Performance and Resources Committee

The Committee Chair (from list above) shall be appointed by the NHS Board at its inaugural meeting. The Committee will appoint a Vice Chair in addition to the Chair. The Chair shall preside at every meeting of the Committee. The Vice Chair shall preside if the Chair is absent.

Appropriate training and development will be provided to ensure that members of the Committee have the skills and knowledge to carry out this role.

2.2 Attendance

Other NHS Non-Executive Board Members may attend Meetings of the Committee and have access to papers at the Committee Chair's discretion. In such cases, NHS Board members should inform the Committee Chair in advance of their desire to attend the relevant Meeting.

The Chief Executive shall normally attend meetings.

The Director of HR shall attend all meetings for the entire agenda to ensure that professional HR advice is available at every stage of proceedings.

3. Meetings of the Committee

3.1 Frequency

The Committee shall meet as required, with Meetings normally to be held three times in each financial year, at a place and time as determined by the Committee Chair. In addition, the Committee Chair may convene Meetings to consider business which may require urgent consideration.

3.2 Agenda and Papers

The Committee Chair in conjunction with the Chief Executive and Director of HR will set the Agenda for meetings.

The Agenda and supporting papers will be sent out at least three clear days in advance of the meetings.

All papers will clearly state the agenda reference, the author, the purpose of the paper and the key issues the Committee is asked to consider using the agreed Board Paper template.

3.3 Quorum

Three Members of the Committee shall constitute a quorum and no business shall be transacted unless this minimum number of Members is present. For the purposes of determining whether a meeting is quorate, Members attending by either video or tele-conference link will be determined to be present.

3.4 Minutes

The Draft Minutes shall then be presented at the next Meeting of the Committee for approval.

A summary of the key items of business considered by the Committee shall be presented, through the Staff Governance Committee as appropriate and made to the next available Board Meeting by the Committee Chair.

3.5 In order to fulfil its remit, the Remuneration Committee can obtain whatever professional advice it requires and invite if necessary external experts to meetings.

4. Duties of the Remuneration Committee

The specific duties of the Committee are as follows:

4.1 In relation to Executive Directors and Health & Care Senior Managers (on executive pay grades):

- review and approve all Terms and Conditions of Employment, including job descriptions, terms of employment, basic pay, performance pay (if applicable) and all benefits associated with each post (this also refers to Senior Managers on executive pay grades)

- review and approve annual performance objectives, including overseeing the review of performance against these objectives at the mid-year point and agreeing any revisions to the objectives during the course of the year (this also refers to Health & care Senior Managers on executive pay grades)
- consider and approve the assessment of performance at the year-end and any changes to the remuneration or the Terms and Conditions of Employment arising from this assessment of performance during the review period (this also refers to Senior Managers on executive pay grades)

4.2 In relation to any other staff employed under Executive Managers' or Consultants' pay arrangements to:

- maintain an overview of remuneration arrangements for staff falling within these categories

4.3 In general:

- comply with any Scottish Government Health and Social Care Directorates directions and take into consideration any relevant guidance on remuneration or terms and conditions of employment
- provide assurance to the Board through the Staff Governance Committee, that systems and procedures are in place to manage the issues set out in Scottish Government guidance so that overarching staff governance responsibilities can be discharged; the Staff Governance Committee will not be given the detail of confidential employment issues that are considered by the Remuneration Committee
- review submissions from the Chief Executive for the terms of any Settlement Agreement; such agreements may also require the approval of the Scottish Government, in accordance with procedures applicable across the public sector

5. Authority

5.1 The Committee is authorised by the NHS Board to obtain external legal or other independent professional advice and to secure the assistance of people from outside the Board or the wider NHS, with relevant expertise, if it is considered necessary.

6. Reporting to the Board

6.1 In addition to providing the Board, through the Staff Governance Committee, with updates, the Remuneration Committee shall produce an Annual Report to the NHS Board and be presented by the Remuneration Committee Chair.

6.2 The Committee has a duty to review its own performance and effectiveness, and terms of reference, on an annual basis and report proposed amendments to the NHS Board.

STAFF GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

1.1 The purpose of the Staff Governance Committee is to provide the NHS Board with the assurance that:

- There is a culture within NHS Forth Valley where the highest possible standard of staff management is understood to be the responsibility of everyone working in Forth Valley and is built upon partnership and collaboration.
- Staff governance mechanisms are in place and effective throughout the local NHS system.
- Performance is reviewed against the Staff Governance standard.

2. COMPOSITION

2.1 Membership

The membership of the Committee shall consist of 6 Non-Executive Members of the NHS Board one of whom must be the Employee Director, one of whom must be the Chair of the NHS Board, and 2 lay representatives from the Trade Unions and Professional Organisation nominated by the Area Partnership Forum resulting in membership as follows:

- Four Non-Executive NHS Board Members
- Chair of the NHS Board
- Employee Director
- Two Lay members

2.2 Appointment of Chairperson and Vice Chair

The Chairperson of the Committee (Non-Executive) shall be appointed at a full business meeting of Forth Valley NHS Board in accordance with Standing Orders. The Committee will appoint a Vice Chair in addition to the Chair. The Chair shall preside at every meeting of the Committee. The Vice Chair shall preside if the Chair is absent.

2.3 Attendance

The Chief Executive of NHS Forth Valley, Director of Nursing and the Director of Human Resources shall normally attend meetings. The Committee can routinely request the attendance of any officer of NHS Forth Valley at its meetings.

All NHS Board Members shall have the right of attendance and have access to papers except where the Committee resolves otherwise.

3. MEETINGS

3.1 Frequency

Meetings of the Committee will be timetabled annually. This schedule should also identify the key items of business to be discussed at each meeting. The Committee shall meet as necessary to fulfil its remit and Meetings will be held at a minimum of once in every quarter.

3.2 Agenda and Papers

The Agenda and supporting papers will be sent out at least three clear days in advance of the meetings. All papers will clearly state the agenda reference, the author, the purpose of the paper together with the action the Committee are asked to consider.

3.3 Quorum

No business shall be transacted unless a minimum of four Staff Governance Committee Members are present.

3.4 Minutes

Formal Minutes will be kept of proceedings and submitted for approval at the next meeting.

Recognising the issue of relative timing and scheduling of meetings, a summary of the key areas of business of the Performance and Resource Committee will be presented to the next Board Meeting to ensure NHS Board members are aware of issues considered and decisions taken.

The draft Minutes will be cleared by the Chair of the Committee and the nominated Lead Executive prior to distribution.

3.5 Other

If necessary, meetings of the Committee shall be convened and attended exclusively by Members of the Committee.

4. REMIT

4.1 Objectives

The main objectives of the Staff Governance Committee are to ensure that staff governance mechanisms are in place and effective throughout the local NHS System and that performance is reviewed against relevant Staff Governance standards. The Committee shall support the creation of a culture within the health system where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the system and is built upon partnership and collaboration.

4.2 Systems Assurance and Staff Governance

- 4.2.1 To receive summary reports from the Area Partnership Forum in relation to Human Resource and Organisational Development Strategy and Policies. Policy development and approval is delegated to the Area Partnership Forum.
- 4.2.2 To monitor implementation of the Workforce Modernisation Agenda through the assessment of regular reports.
- 4.2.3 To commission the introduction of structures and processes which ensure that delivery against the Staff Governance Standards, including the aligned Whistleblowing Standards, is being achieved.
- 4.2.4 To ensure consistency of policy and equity of treatment of employees.
- 4.2.5 To ensure that a consistent approach to the job evaluation is in place.
- 4.2.6 To monitor Workforce Plan development and its associated action plan.
- 4.2.7 To ensure that an appropriate approach is in place to deal with staff risk management (including staff and patient safety) across the system working within NHS Forth Valley Risk Management Strategy.
- 4.2.8 To provide staff governance information for the statement of internal control.

4.3 Internal Review

- 4.3.1 To monitor and evaluate strategies and implementation plans relating to people management.
- 4.3.2 To review staff survey results and to monitor implementation of agreed action plans.
- 4.3.3 To monitor performance in NHS Forth Valley in
 - staff communications
 - learning and development
 - partnership working (through links with Area Partnership Forum)
 - safe and healthy working environment
 - Human Resource Policies and Procedures
- 4.3.4 To propose and support any policy amendment, funding, or resource submission to achieve the Staff Governance Standard recognising that such proposals will require to be assessed as part of the overarching local prioritisation process.
- 4.3.5 To receive minutes from Health and Safety Committee and to monitor governance arrangements as they relate to staff.

4.4 External Review

4.4.1 To take responsibility for the timely submission of all staff governance information required for national monitoring arrangements and ensure follow-up action is taken in respect of relevant external reviews such as Audit Reports.

4.4.2 To oversee the implementation of Everyone Matters, the national workforce vision and related workforce strategies.

- Partnership Information Network Guidelines
- Fair for All

4.4.3 To review all appropriate Performance elements routinely.

4.4.4 To recognise the implementation of the 'Once for Scotland' Workforce Policies.

5. Other

5.1 The Committee has a duty to review its own performance, effectiveness, including running costs and Terms of Reference on an annual basis.

5.2 The Chairman shall submit an Annual Report on the work of the Committee to the NHS Board.

5.3 The Committee is authorised to obtain professional advice it considers necessary.

ANNEX C: STANDING ORDERS

SCHEME OF DECISIONS RETAINED BY FORTH VALLEY NHS BOARD

The Code of Accountability requires the NHS Board to adopt a Schedule of Decisions that are reserved for the NHS Board. The following decisions are for determination by the NHS Board: -

1. Values and aims of Forth Valley NHS Board
2. Forth Valley Corporate Plan including the Local Delivery Plan and Regional Planning issues
3. Strategic Health Service Plans, all Business Cases where Capital Investment exceeds £1m
4. Five Year Financial Plan and Annual Financial Plan
5. Five Year Capital Plan and Annual Capital Plan
6. Endorsement of jointly published plans with public sector partners
7. Standing Orders including Decisions retained by the Board and the Scheme of Delegation
8. Standing Financial Instructions
9. Establishment, terms of reference, reporting arrangements and membership of all Committees acting on behalf of the NHS Board
10. NHS Board Members' Register of Interests
11. Approval of NHS Board Annual Report and Annual Accounts
12. Financial and Performance Management Reporting Arrangements
13. Arrangements for approval of policies required as a result of national guidelines with the exception of Human Resource policies (see Staff Governance Committee remit)
14. Recommendations to the Scottish Government relating to the closure or change of use of hospitals
15. Acquisition and disposal of any land and property above £ 250,000
16. Appointment of Executive Directors of Forth Valley NHS Board
17. Appointment of Management Consultants/Advisors where contract value exceeds £100,000
18. Approval of delegation of any function to an agency out with the National Health Service

The Chief Executive is authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chairperson and the Vice Chairperson of the Board and the

relevant Standing Committee Chairperson. Where such powers are invoked these shall be formally reported to the next relevant Standing Committee or NHS Board Meeting as appropriate.

ANNEX D: STANDING ORDERS

SCHEME OF DELEGATION

A clear set of rules for delegation, inclusive of financial limits is essential to ensure that effective management control of resources is exercised.

Decisions retained by the NHS Board are identified in Annex C.

All powers not retained by the NHS Board or delegated to a Committee or Sub-Committee shall be exercised on behalf of the NHS Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he/she shall perform personally, and which functions have been delegated to other Officers.

The Chief Executive as Accountable Officer (Revised Memorandum to National Health Service Accountable Officers: May 2002) is also accountable to the Principal Accounting Officer of the NHS in Scotland and the Scottish Parliament. The role of the Director of Finance in devising, implementing, monitoring and supervising systems of financial control is exercised on behalf of the Chief Executive and the NHS Board.

The Scheme of Delegation and the Standing Financial Instructions form a major part of the system of control. These should be used in conjunction with the system of budgetary control and other established procedures.

SECTION B

Code of Conduct

SECTION 1: THE CODE OF CONDUCT

1.1 Introduction

- 1.1.1 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.
- 1.1.2 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 established a Standards Commission for Scotland, “The Standards Commission” to oversee the new framework and deal with alleged breaches of the codes.
- 1.1.3 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 was revised in December 2013 following consultation and the approval of the Scottish Parliament. These revisions 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.
- 1.1.4 As a member of Forth Valley NHS Board, “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.

1.2 Appointments to the Boards of Public Bodies

- 1.2.1 Public bodies in Scotland are required to deliver effective services to meet the needs 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.
- 1.2.2 You should also familiarise yourself with how the public body’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.

1.3 Guidance on the Code of Conduct

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

1.3.2 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 the public body. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

1.3.3 You should familiarise yourself with the Scottish Government publication “On Board – 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.

1.4 Enforcement

1.4.1 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

2.1 Key Principles of the Code of Conduct

2.1.1 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 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 the public body 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 the public body 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 the public body and its members in conducting public business.

- **Respect**

You must respect fellow members of your public body and employees of the body and the role they play, always treating them with courtesy. Similarly, you must respect members of the public when performing duties as a member of your public body.

2.1.2 You should apply the principles of this Code to your dealings with fellow members of the public body, 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 the public body.

SECTION 3: CONDUCT

3.1 General Conduct

- 3.1.1 The rules of good conduct in this section must be observed in all situations where you act as a member of the public body.

3.2 Conduct at Meetings

- 3.2.1 You must respect the chair, your colleagues, and employees of the public body in meetings. You must comply with rulings from the chair in the conduct of the business of these meetings.

3.3 Relationship with Board Members and Employees of the Public Body (including those employed by contractors providing services)

- 3.3.1 You will treat your fellow board members and any staff employed by the body 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 the public body in relation to bullying and harassment in the workplace and lead by exemplar behaviour.

3.4 Remuneration, Allowances and Expenses

- 3.4.1 You must comply with any rules of the public body regarding remuneration, allowances, and expenses.

3.5 Gifts and Hospitality

- 3.5.1 You must not accept any offer by way of gift or hospitality which could give rise to real 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.
- 3.5.2 You must never ask for gifts or hospitality.
- 3.5.3 You are personally responsible for all decisions connected with the offer or acceptance of gifts or hospitality offered to you and for avoiding the risk of damage to public confidence in your public body. 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 the public body.

- 3.5.4 You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision your body 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 your public body then, as a general rule, you should ensure that your body pays for the cost of the visit.
- 3.5.5 You must not accept repeated hospitality or repeated gifts from the same source.
- 3.5.6 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.

3.6 Confidentiality Requirements

- 3.6.1 There may be times when you will be required to treat discussions, documents or other information relating to the work of the body 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.
- 3.6.2 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 the public body into disrepute.

3.7 Use of Public Body Facilities

- 3.7.1 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 the public body'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 the public body.

3.8 Appointment to Partner Organisations

- 3.8.1 You may be appointed, or nominated by your public body, 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.
- 3.8.2 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 the public body. It is your responsibility to take advice on your responsibilities to the public body and to the company. This will include questions of declarations of interest.

SECTION 4: INTERESTS

4.1 Registration of Interests

- 4.1.1 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 the body’s Register. It is your duty to ensure any changes in circumstances are reported within one month of them changing.
- 4.1.2 The Regulations¹ 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 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.

4.2 Category One: Remuneration

- 4.2.1 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
- 4.2.2 In relation to 4.2.1 above, the amount of remuneration does not require to be registered and remuneration received as a member does not have to be registered.
- 4.2.3 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”.
- 4.2.4 If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.
- 4.2.5 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.
- 4.2.6 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.

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

- 4.2.7 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.
- 4.2.8 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.
- 4.2.9 Registration of a pension is not required as this falls outside the scope of the category.

4.3 Category Two: Related Undertakings

- 4.3.1 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.
- 4.3.2 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.
- 4.3.3 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.

4.3 Category Three: Contracts

- 4.4.1 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 4.6.1 below) have made a contract with the public body of which you are a member:
- under which goods or services are to be provided, or works are to be executed; and
 - which has not been fully discharged.
- 4.4.3 You must register a description of the contract, including its duration, but excluding the consideration.

4.5 Category Four: Houses, Land and Buildings

- 4.5.1 You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed.
- 4.5.2 The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision making.

4.6 Category Five: Interest in Shares and Securities

- 4.6.1 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) the body to which you are appointed 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.
- 4.6.2 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.

4.7 Category Six: Gifts and Hospitality

- 4.7.1 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 3.5.3 (a) to (c) of this Model Code.

4.8 Category Seven: Non-Financial Interests

- 4.8.1 You may also have a registerable interest if you have non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed. 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.
- 4.8.2 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 the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making.

SECTION 5: DECLARATION OF INTERESTS

5.1 General

- 5.1.1 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 the public body. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions.
- 5.1.2 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 the public body and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.
- 5.1.3 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.

- 5.1.4 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 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 exists, they should seek advice from the board chair.
- 5.1.5 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 3.8.2 of this Model Code about your legal responsibilities to any limited company of which you are a director.

5.2 Interests which Require Declaration

- 5.2.1 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.
- 5.2.2 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.

5.3 Your Financial Interests

- 5.3.1 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:

- as an employee of the Board or
- 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 are not required, for that reason alone, have to declare that interest.

5.3.2 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.

5.3.3 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.

5.4 Your Non-Financial Interests

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

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

5.4.2 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.

5.5 The Financial Interests of Other Persons

5.5.1 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.

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

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

5.5.3 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.

- 5.5.4 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.
- 5.5.4 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 the public body and, as such, would be covered by the objective test.

5.6 The Non-Financial Interests of Other Persons

- 5.6.1 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.
- 5.6.2 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.
- 5.6.3 There is only a need to withdraw from the meeting if the interest is clear and substantial.

5.7 Making a Declaration

- 5.7.1 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.
- 5.7.2 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.

5.8 Frequent Declarations of Interest

- 5.8.1 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.

5.9 Dispensations

- 5.9.1 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.
- 5.9.2 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

6.1 Introduction

- 6.1.1 In order for the public body to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which the public body conducts its business.
- 6.1.2 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.

6.2 Rules and Guidance

- 6.2.1 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 the public body or any statutory provision.
- 6.2.2 You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon the public body.
- 6.2.3 The public must be assured that no person or organisation will gain better access to or treatment by, you as a result of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a fee basis on behalf of clients be given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of the public body.
- 6.2.4 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.
- 6.2.5 You should not accept any paid work:
 - (a) which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation.
 - (b) to provide services as a strategist, adviser, or consultant, for example, advising on how to influence the public body and its members. This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the public

body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences, or other events.

- 6.2.6 If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of the public body.

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 like 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.

SECTION C

Standards of Business Conduct For NHS Staff

1. Introduction

- 1.1** This section of NHS Forth Valleys Code of Corporate Governance provides instructions on those issues or matters which staff are most likely to encounter in carrying out their day to day duties. This is not exhaustive and is supplementary to (and therefore should be read in conjunction with the Standards of Business Conduct for NHS Staff (NHS Circular MEL (1994) 48) and A Common Understanding of 2021: Working Together for Patients.
- 1.2** The Standards of Business Conduct for NHS Staff will be incorporated into the contract of employment for each member of staff.
- 1.3** Guidance regarding accepted practice in NHS Forth Valley is detailed in these standards: however, professionally registered staff should also ensure that they do not breach the requirements in respect of their Professional Codes of Conduct.

2. The Bribery Act 2010 – NHS Forth Valley’s Aims and Objectives

- 2.1** The Bribery Act 2010 (“The Act”) has brought further obligations on NHS Forth Valley, its Non-Executive Members and its staff.
- 2.2** NHS Forth Valley does not tolerate any form of bribery, whether direct or indirect, by, or of, its staff, agents or external consultants or any persons or entities acting for it or on its behalf. This includes Non-Executive Member, and any other co-opted members of committees or sub-committees of the Board.
- 2.3** The Board is committed to implementing and enforcing effective systems throughout NHS Forth Valley to prevent, monitor and eliminate bribery within NHS Forth Valley, in accordance with the Bribery Act 2010, and to the rigorous investigation of any such cases.
- 2.4** NHS Forth Valley will not conduct business with services 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 Forth Valley with immediate effect where there is evidence that they have committed acts of bribery.
- 2.5** The Success of NHS Forth Valley’s anti-bribery measures depends on all employees, Non-Executive Members and those acting for NHS Forth Valley, playing their part in helping to detect and eradicate bribery. Therefore, all employees, Non-Executive Members and others acting for or on behalf of NHS Forth Valley are encouraged to report and suspected bribery in accordance with bribery in accordance with The Fraud Standards, Section D, of the Code of Corporate Governance.

3. The Bribery Act 2010 – Key Points

- 3.1** The Bribery Act 2012 is on a strict piece of legislation and makes it a criminal offence for any individual (employee, contractor, agent) associated with NHS Forth Valley, to give, promise or offer a bribe, and to request, agree to receive or accept a bribe (sections 1, 2 and 6 offences). This can be punishable by imprisonment of up to ten years.

- 3.2** In addition, the Act introduces a corporate offence (Section 7 offence) which means that NHS Forth Valley can be exposed to criminal liability, punishable by an unlimited fine, 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 Forth Valley, in the course of their work. NHS Forth Valley takes its legal responsibilities very seriously.
- 3.3** 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 Forth Valley, under the Act, the Director or Senior Officer would be guilty of an offence (section 14 offences) as well as the body corporate which paid the bribe.
- 3.4** Whilst the exact definition of bribery and corruption is a statutory matter, the following working definitions are given together with some examples:

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 misuse 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.

Examples of bribery:

Offering a Bribe

A bribe would occur if:

- A payment was made to influence an individual who was responsible for making decision on whether NHS Forth Valley should be selected as preferred bidder for the provision of services in a procurement process.
- A member of staff conducted private meetings, other than on NHS premises, with a public contractor hoping to tender an NHS Forth Valley contract, each time accepting hospitality far in excess of that deemed appropriate within the Standards of Business Conduct for NHS Forth Valley and without guidance being sought in advance from the line manager or Corporate Services Manager Board Secretary, or subsequently being declared.

Receiving a Bribe

A bribe would occur if:

- A patient offered a member of NHS Forth Valley staff a payment (or other incentive) to speed up, beyond usual timeframe, the provision of a particular aspect of their care.

- A pharmaceutical company offered a member of NHS Forth Valley staff a payment (or other incentive such as a generous gift or lavish hospitality) in order to influence their decision making in the selection of a pharmaceutical product to appear on NHS Forth Valley's drug formulary.

3.5 The success of NHS Forth Valley's anti-bribery measures depends on all employees, and those acting for NHS Forth Valley, playing their part in helping to detect and eradicate bribery. Therefore, all employees and others acting for or on behalf of NHS Forth Valley are encouraged to report any suspected bribery in accordance with following The Fraud Standards, Section D, of the Code of Corporate Governance.

4. Responsibilities of Staff

4.1 NHS Forth Valley is committed to maintaining strict ethical standards and integrity in the conduct of its business activities. All NHS Forth Valley Staff and individuals acting on NHS Forth Valley's behalf, are responsible for conducting NHS Forth Valley's business professionally, with honesty, integrity and maintain the organisation's reputation and free from bribery.

4.2 Staff must ensure that they do not place themselves in a position which risks, or appears to risk, conflict between their private interests and their NHS duties such as, for example, abusing their present position to obtain preferential rates for personal gain or to benefit family members or associates.

This primary responsibility applies to **all NHS staff**, but is of particular relevance to those who commit NHS resources directly (e.g., by the ordering of goods) or those who do so indirectly (e.g., by the prescribing of medicines).

4.3 The NHS must be impartial and honest in the conduct of its business and its employees should remain beyond suspicion.

4.4 Staff need to be aware that a breach of the provisions of the Bribery Act renders them liable to prosecution and may lead to potential disciplinary action and the loss of their employment and superannuation rights.

4.5 This Code reflects the minimum Standards of Business Conduct expected from all NHS staff. Any breaches of the Code may lead to disciplinary action.

N.B: If you are in any doubt at all as to what you can or cannot do, you should seek advice from your Line manager/Head of Department/ Director of Finance or Corporate Business Manager

5. Key Principles of Business Conduct

5.1 The Standards of Business Conduct for NHS Staff [MEL (1994) 48] provide instructions to staff in maintaining strict ethical standards in the conduct of NHS business. All staff are therefore required to adhere to the Standards of Business Conduct for NHS Staff.

5.2 Public Service values must be at the heart of the NHS Board's activities. High standards of corporate and personal conduct, based on the recognition that patients come first, are mandatory. The NHS Board is a publicly funded body, accountable to Scottish Ministers and through them to the Scottish

Parliament for the services and for the economical, efficient, and effective use of resources placed at the Board's disposal.

- 5.3** By staff following these principles, the Board should be able to demonstrate that it adheres to the three essential public sector values.

Accountability: Everything done by those who work in the organisation must be able to stand these tests of parliamentary scrutiny, public judgements on propriety, and meet professional codes of conduct.

Probity: Absolute honesty and integrity should be exercised in dealing with NHS patients, staff, assets, 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 public.

6. Acceptance of Gifts, Hospitality and Prizes

6.1 Gifts

- 6.1.1 The Standards of Business Conduct state that any money, gift, or consideration received by an employee in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary.

- 6.1.2 Staff should therefore be very cautious if faced with the offer of a gift. Casual gifts offered by contractors or others excluding patients, relatives, or carers (for example, at the festive season) may not be in any way connected with the performance of duties to constitute an offence. Such gifts should nevertheless be declined. Items of low intrinsic value e.g., boxes of biscuits, chocolates or flowers from patients, relatives, or carers can be accepted. Any gifts of money should be handled in accordance with the Endowment Fund Charter.

Where an unsolicited or inappropriate gift is received and the individual is unable to return it or the donor refuses to accept its return, they should report the circumstances to the Corporate Services Manager who will determine if the gift can be accepted, and this should be recorded in the Register of Gifts.

Financial donations to a department fund, which are to be used for the purposes of NHS Forth Valley must be administered through Forth Valley Health Board Endowment Fund and handled in accordance with the Endowment Fund Charter.

The Corporate Services Manager should maintain a register to record gifts reported by staff. It is the responsibility of the recipients of such gifts to report all such items received to the Corporate Services Manager for recording who will provide the registration form. The register will be published on the NHS Forth Valley website.

6.2 Hospitality

- 6.2.1 Standards of Business Conduct state that hospitality may be acceptable provided it is normal and reasonable in the circumstances e.g., lunches during a working visit. Any hospitality accepted should be similar in scale to that which the NHS as an employer would be likely to offer and must not exceed £25. All other offers of hospitality should be declined.
- 6.2.2 Staff should seek guidance from their Line Manager prior to accepting any such hospitality. In cases of doubt, advice should be sought from the Corporate Services Manager.
- 6.2.3 It may not always be clear whether an individual is being invited to an event involving the provision of hospitality (e.g., formal dinner) in a personal/private capacity or as a consequence of the position which they hold in NHS Forth Valley.
- I. If the invitation is the result of the individual's position with NHS Forth Valley, only hospitality which is modest and normal and reasonable in the circumstances should be accepted. If the nature of the event dictates a level of hospitality which exceeds this, then the individual should ensure that his/her Head of Department/Director is fully aware of the circumstances. An example of such an event might be an awards ceremony involving a formal dinner. If the Head of Department/Director grants approval to attend, the individual should declare his/her attendance for registration in the Register of Hospitality held by the Corporate Services Manager.
 - II. If the individual is invited to an event in a private capacity (e.g., as result of his/her qualification or membership of a professional body), they are at liberty to accept or decline the invitation without referring to his/her Line Manager. The following matters should however be considered before an invitation to an individual in a private capacity is accepted.
 - The individual should not do or say anything at the event that could be construed as representing the views and/or policies of NHS Forth Valley.
 - If the body issuing the invitation has (or is likely to have or is seeking to have) commercial or other financial dealings with NHS Forth Valley, then it could be difficult for an individual to demonstrate that his/her attendance was in a private and not an official capacity. Attendance could create a perception that the individual's independence had been compromised, especially where the scale of hospitality is lavish. Individuals should therefore exercise caution before accepting invitations from such bodies and must seek approval from their Line Manager.
 - III. Where suppliers of clinical products offer hospitality, it should only be accepted if it complies with the guidance in the Sponsorship Policy.
 - IV. The Corporate Services Manager should maintain a register to record hospitality reported by staff. It is the responsibility of the recipients of such hospitality to report all such items received to the Corporate Services Manager for recording in NHS Forth Valley's Register of Hospitality. The form in Annex 2 should be used for this purpose. This register will be published on the NHS Forth Valley website.

6.3 Competitions/Prizes

Individuals should not enter competitions including free draws organised by bodies who have or are seeking to have financial dealings with NHS Forth Valley. Potential suppliers may use this as a means of giving money or gifts to individuals with NHS Forth Valley to influence the outcomes of business decisions. If in doubt, contact the Corporate Services Manager.

7. Register of Staff Interests

7.1 To avoid conflicts of interest and to maintain openness and accountability, employees, are required to register all interests that may have any relevance to their duties/responsibilities. These include any financial interest in a business or any other activity or pursuit that may compete for an NHS Contract to supply either goods or services to the NHS or in any other way could be perceived to conflict with the interests of NHS Forth Valley. The test to be applied when considering appropriateness of registration of an interest is to ask whether a member of the public acting reasonably might consider the interest could potentially affect the individual's responsibilities to the organisation and/or influence their actions. If in doubt the individual should register the interest or seek further guidance from the Corporate Services Manager.

7.2 Interests that it may be appropriate to register, include:

- (i) Other employments including self-employment
- (ii) Directorships including Non-Executive Directorships held in private companies or public limited companies (whether remunerated or not)
- (iii) Ownership of, or an interest in, private companies, partnerships, businesses, or consultancies
- (iv) Shareholdings in organisations likely or possibly seeking to do business with the NHS (the value of the shareholdings need not be declared)
- (v) Ownership of or interest in land or buildings which may be significant to, of relevance to, or bear upon the work of NHS Forth Valley
- (vi) Any position of authority held in another public body, trade union, charity, or voluntary body
- (vii) Any connection with a voluntary or other body contracting for NHS services
- (viii) Any involvement in joint working arrangements with Clinical (or other) Suppliers

This list is not exhaustive and should not preclude the registration of other forms of interest where these may give rise to a potential conflict of interest upon the work of NHS Forth Valley. Any interests of spouses, partner or civil partner, close relative or associate, or persons living with the individual as part of a family unit, will also require registration if a conflict of interests exists.

7.3 The completed register of interests' form should be returned to the Board Secretary. The Register of Staff Interests will be retained for a period of five years.

7.4 It is the responsibility of everyone to declare any relevant interest to the Chair of any Committee/decision making group of which they are a Member so that the Chair is aware of any conflict which may arise.

8. Purchase of Goods and Services

- 8.1** NHS Forth Valley has a procurement function under the direction of the Director of Finance to purchase the goods and services required for the functioning of NHS Forth Valley. Except for staff who have delegated authority to purchase goods and services, no other member of staff is authorised to make a commitment to a third party for the purchase of goods or services. The procurement Officer should be contacted for advice on all aspects of the purchase of goods and services.
- 8.2** All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contractors for goods, materials or services are expected to adhere to Section 13 of NHS Forth Valley's Standing Financial Instructions (SFIs).
- 8.3** Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of SFIs and of EC Directives on Public Purchasing for Works and Supplies. This means that:
- No private or public company, firm or voluntary organisation which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors whether there is a relationship between them and the NHS employer, such as a long-running series of previous contracts.
 - Each new contract should be awarded solely on merit in accordance with SFIs.
- 8.4** Types of property transactions and these rules require that, each year, all NHS Forth Valley's property transaction are subject to scrutiny by the Audit Committee. The results of this scrutiny are reported to Scottish Government. Failure to comply with the rules governing property transactions could be SFIs describe the process to be followed to purchase goods and services Key points to note are:
- (i) SFIs define the limits above which competitive quotations and competitive tenders must be obtained and describe the process which should be followed to achieve fair and open competition.
 - (ii) No organisation should be given unfair advantage in the competitive process, e.g., by receiving advance notice of NHS Forth Valley's requirements.
- 8.5** No special favour should be shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or managerial capacity.
- 8.6** Contracts must be won in fair competition against other tenders and scrupulous care should be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.
- 8.7** All invitations to potential contractors to tender for NHS business should include a notice warning the tenderer of the consequences of engaging in any corrupt practices involving NHS Forth Valley's employees and that facilitation payments are prohibited in line with the Bribery Act 2010.

9. Purchase, Sale and Lease of Property

- 9.1** Scottish Government have issued a strict set of rules governing all viewed as a serious disciplinary matter.
- 9.2** Where it is necessary to acquire, dispose of or lease property land and/or buildings, the proposed transaction should be referred to the Head of Finance in the first instance, who is responsible for property matters, including the conduct of all property transactions.
- 9.3** Authority to sign off property transactions is limited to officers to whom authority has been formally and specifically delegated by Scottish Ministers.

Their officers are:

- Chief Executive
- Director of Finance

- 9.4** No other member of staff is authorised to make any commitment in respect of the acquisition or disposal of property or interest in property, e.g., leases.

10. Benefits Accruing from Official Expenditure

The underlying principle is to obtain best value from public expenditure and decisions should not be determined by private/personal benefit.

- 10.1** Staff should not use their official position for personal gain or to benefit their family and friends.
- 10.2** Employees should not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had or may have official dealings on behalf of NHS Forth Valley. This does not apply to concessionary agreements negotiated on behalf of NHS staff.

11. Free Samples

- 11.1** Free samples should not be accepted.

12. Outside Interests and Secondary Employment

- 12.1** Outside interests include directorships, ownership, part-ownership or material shareholdings in companies, business, or consultancies likely to seek to do business with the NHS. These should be declared to the individual's line manager, as should the interests of a spouse/partner or close relative.
- 12.2** In principle, staff can accept additional employment out with NHS Forth Valley in their own time. It is also possible that a conflict of interest may arise because of an employee accepting an outside post that is with a company that does business, or is in competition with, the NHS. Where this is any doubt, the employee must seek advice from their manager before accepting any outside post. Additional employment must have no adverse effect on the work of NHS Forth Valley or their own performance. The resources of NHS Forth Valley cannot be used in external employment.

13. Acceptances of Fees

13.1 Where staff are offered fees by outside agencies, including a clinical supplier, for undertaking work or engagements (e.g., radio or TV interviews, lectures, consultancy advice, membership of an advisory board, etc.) within their normal hours, or draw on his/her official experience, the employee's Line Manager must be informed and his/her written approval obtained before any commitment is given by the employee. Directors must obtain written approval from the Chief Executive and the Chief Executive must obtain written approval from the Chair of NHS Forth Valley before committing to such work.

An assurance will be required that:

- (i) The individual concerned is not making use of his/her NHS employment to further his/her private interests
- (ii) Any outside work does not interfere with the performance of his/her NHS duties
- (iii) Any outside work will not damage NHS Forth Valley's reputation

13.2 If the work carried out is part of the employee's normal duties or could reasonably be regarded as falling within the normal duties of the post, then any fee due is the property of NHS Forth Valley and it should be NHS Forth Valley (and not the individual) that issues any invoice required to obtain payment. The individual must not issue requests for payment in his/her own name. The individual must pass the relevant details to the Director of Finance.

13.3 Employees should not commit to any work which attracts a fee until they have obtained the required written approval as described in paragraph 12.1. It is possible that an individual may undertake work and not expect a fee but then receive an unsolicited payment after the work in questions have been completed. The principle set out in paragraph 12.2 applies where an unsolicited payment is received.

13.4 It is also possible that an individual may be offered payment in kind, e.g. book tokens. The principle is that these should be refused.

13.5 A gift offered in respect of work undertaken as part of the individual's normal duties should be declined.

14. Contact with the Media

14.1 To achieve consistency and appropriateness of sometimes sensitive public messages, only authorised staff may speak to the media. Should you be contacted by the press you should refer to the office of the Chief Executive.

14.2 Staff must not invite journalists, photographers, or camera crew onto any NHS Forth Valley's premises without the prior agreement of the Chief Executive.

14.3 Where an individual exercises the right in a private capacity to publish an article, give an interview or otherwise participate in a media event or debate in a public forum (including the internet), they should make it clear that they are acting in a private capacity and any opinions expressed are not those of NHS Forth Valley. This should be agreed in principle with your line manager.

15. Conduct During Elections

15.1 General Principles

Scottish Government issue regular guidance to health bodies about their roles and conduct during election campaigns. The following general principals are set out:

- (i) There should be even-handedness in meeting information requests from candidates from different political parties. Such requests should be handled in accordance with the principals laid down in the election guidance and the Freedom of Information (Scotland) Act 2002.
- (ii) Care should be taken over the timing of announcements of decisions made by NHS Forth Valley to avoid accusations of political controversy or partisanship. In some cases, it may be better to defer an announcement until after the election, but this would have to be balanced against any implication that the deferral itself could influence the outcome of the election. Each case should be considered on its merits and any cases of doubt should be referred to the Scottish Government for advice.
- (iii) Existing advertising campaigns should be closed and there should be a general presumption against undertaking new campaigns unless agreement has been reached in advance with Scottish Government.
- (iv) In carrying out day to day work and corporate activities, care should be taken to do nothing which could be construed as politically motivated or as taking a political stance.

Public resources must not be used for party political purposes.

15.2 Freedom of Information (Scotland) Act 2002

The Freedom of Information (Scotland) Act 2002, (FOISA) remains in full force during the election period. FOISA requests should continue to be dealt with in accordance with normal procedures. Scottish Government should be consulted in advance or responding to requests which are thought likely to impact on the election campaign in any way.

16. Intellectual Property Rights

If an employee invents a new technology, for instance, a device or diagnostic, or otherwise creates intellectual property (IP) as part of the normal duties of their employment, the patent rights in the invention belong to the employer (Patents Act 1977). Although legally the employee is not automatically entitled to any royalty or reward derived from such an invention, they would expect to be acknowledged as the inventor in any patent application. The Director of Finance should see that this effected.

Full guidance is available in circulars MEL (1998) 23 and MEL (2004) 9.

17. Sponsorship

- 17.1** Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable but only where the employee seeks permission in advance from the relevant Director, and the employer is satisfied that the acceptance will not compromise purchasing decisions in any way.
- 17.2** On occasions when NHS employers consider it 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) the employer will meet the cost to avoid putting jeopardy the integrity of subsequent purchasing decisions.
- 17.3** Companies may offer to sponsor wholly or partially a post. The employer will not enter such an arrangement unless it is made abundantly clear to the company concerned that sponsorship would have no effect on the purchasing decision with NHS Forth Valley. Where the sponsorship is accepted, the Director of Finance will be fully involved and will establish monitoring arrangements to ensure that purchasing decisions are not being influenced by the sponsorship agreement.
- 17.4** Under no circumstances should any employee agree to deals where sponsorship is linked to the purchase of a particular product or to supply from sources.

18. Remedies

- 18.1** Managers or staff who fail to comply with the guidance detailed in this code 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 the NHS Forth Valley 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 or the Director of Finance.

19. Communication

- 19.1** This code is applicable to every NHS Forth Valley employee and therefore it is imperative that all staff are informed of its contents. Each manager with NHS Forth Valley will receive a copy of the code and will confirm their receipt and understanding of the code in writing as well as confirming that they have a permanent record of formally informing their staff.

20. Contact for further guidance

- 20.1** The Corporate Business Manager will provide advice and guidance on the Standards of Business Conduct for NHS staff and its interpretation.

21. Review Process

The Standards of Business Conduct for NHS Staff will be reviewed annually.

SECTION D

The Fraud Standards

The Fraud Standards

Fraud Policy

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Key Contacts

Annex 1

FRAUD POLICY

1. Introduction

- 1.1 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 and the means of enforcing the rules against fraud/theft and other illegal acts involving corruption, dishonesty, or damage to property.
- 1.2 NHS Forth Valley (the Board) has procedures in place that reduce the likelihood of fraud occurring. These include Standing Orders (SOs), Standing Financial Instructions (SFIs), operational procedures, a system of internal control and risk assessment. NHS Forth Valley engages CFS to promote a fraud awareness culture through a range of products and services. The Partnership Agreement (PA) includes reference to the Board and CFS proactively detecting and investigating fraud and assessing the risk of fraud and forms a key element of the Scottish Government's determination to counter fraud against NHS Scotland. This guidance is in line with the PA between NHS Forth Valley and the NHS Scotland Counter Fraud Services.
(See: <http://www.sehd.scot.nhs.uk/publications/DC20190319CFS.pdf>)

2. Purpose of the Fraud Standards

- 2.1 The purpose of this document is to provide guidance to employees on the action, which should be taken when fraud, theft or corruption is suspected. Such occurrences may involve employees of NHS Forth Valley, Suppliers/Contractors or any third party. This document sets out the Board's policy and response plan for detected or suspected fraud. It is not the purpose of this document to provide direction on the prevention of fraud.
- 2.2 The Partnership Agreement is referenced in the Fraud section of the Scottish Public Finance Manual. This can be found at:
<https://www.gov.scot/publications/scottish-public-finance-manual/fraud-and-gifts/fraud/>
- 2.3 Whilst the exact definition of theft, fraud or corruption is a statutory matter, the following working definitions are given for guidance:
- Theft is removing property belonging to NHS Forth Valley, its staff, or patients with the intention of permanently depriving the owner of its use, without their consent.
 - Fraud or corruption 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.

For simplicity this document will refer to all such offences as "*fraud*", except where the context indicates otherwise.

- 2.4 NHS Forth Valley already has procedures in place, which reduce the likelihood of fraud/theft occurring. These include within the Standing Orders, Standing Financial Instructions and accounting

procedures, a system of internal control and a system of risk assessment. The Board also has a payment verification system which concentrates on Primary Care expenditure.

- 2.5 It is the responsibility of NHS Forth Valley 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.

3. Public service values

- 3.1 The expectation of high standards of corporate and personal conduct 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.

- 3.2 All those who work in the organisation should be aware of, and act in accordance with, the above values. In addition, NHS Forth Valley will expect and encourage a culture of openness between NHS bodies and the sharing of information in relation to any fraud.

4. NHS Forth Valley Policy, Public Interest Disclosure Act 1998 and Bribery Act 2010

- 4.1 NHS Forth Valley is committed to the NHS Scotland Counter Fraud Strategy and to the public service values outlined above. NHS Forth Valley is dedicated to maintaining an honest, open and well intentioned atmosphere within the service and to the deterrence, detection and investigation of any fraud within the organisation.
- 4.2 NHS Forth Valley encourages anyone having reasonable suspicion of fraud to report the incident. It is NHS Forth Valley 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 rose maliciously.
- 4.3 In addition, the Public Interest Disclosure Act 1998 protects whistleblowers from negative treatment or unfair dismissal. 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.
- 4.4 NHS Forth Valley Whistleblowing Arrangements Policy aims to ensure that staff can safely raise concerns where they are witness to risk, malpractice or wrongdoing that affects others. Employees can be assured that concerns raised in good faith will be protected under current legislation. NHS Forth Valley staff can continue to raise any concerns with their line manager in the first instance and

they can also seek support and advice from Human Resources (HR), staff-side representatives and occupational health in line with existing policies and procedures. Details of the support available to staff and copies of current national and local policies (including the Bullying and Harassment Policy and Grievance Policy) can be found in the HR Connect section of the NHS Forth Valley staff intranet. Confidential Contacts are available via email on fv.confidentialcontact@nhs.scot or by telephone 07815478106.

- 4.5 Whistleblowing standards have been introduced from 1 April 2021 across NHS Scotland. The standards include the role of an Independent National Whistleblowing Officer which forms part of the Scottish Public Services Ombudsman. The phone line, 0800 008 6112 is open to anyone who wishes to raise concerns about practices in NHS Scotland. The focus of the new National Whistleblowing Policy in NHS Scotland is to:

- help staff raise concerns as early as possible, and,
- support and provide protection for staff when they raise concerns.

The Whistleblowing standards aim to support an open fair and just culture, where concerns can be raised early and dealt with promptly and professionally. The process set out by the National Whistleblowing Standards is a formal process.

- 4.6 Whilst we would encourage staff to raise any concerns or complaints through existing Board procedures, the National Confidential Alert Line for NHS Scotland employees has been established to provide an additional level of support for NHS employees who may wish to raise a concern about practices in NHS Scotland. This service is run by Protect, an independent whistleblowing charity. The Alert Line offers independent, confidential advice from legally trained expert staff on whether and how to raise a concern and can be contacted on 020 74046609. Further choices available to staff, patients and members of the public for reporting suspicions of fraud (either anonymously or as a named individual) are:

- the CFS Fraud Hotline, which is now powered by Crimestoppers, on 08000 15 16 28; or
- directly through the CFS Website on www.cfs.scot.nhs.uk.

- 4.7 The NHS Forth Valley Policy on Standards of Personal Business Conduct describes the minimum Standards of Business Conduct expected from all NHS staff. It is the responsibility of staff to ensure that they do not place themselves in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

Under the Bribery Act 2010:

- It is a criminal offence to give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad;
- The maximum penalty for bribery was increased from seven to 10 years imprisonment with an unlimited fine;
- It is a corporate offence of failure to prevent bribery by persons working on behalf of a business, which means that NHS Forth Valley can be exposed to criminal liability, punishable by an unlimited fine if it fails to prevent bribery by not having adequate procedures in place that are robust, up to date and effective. The corporate offence is not a standalone offence and will follow from a bribery/ corruption offence committed by an individual associated with NHS Forth Valley, in the course of their work. NHS Forth Valley therefore takes its legal responsibilities very seriously.

- 4.8 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 Forth Valley, 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.
- 4.9 Staff must 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 the loss of their employment and superannuation rights within the NHS.
- 4.10 NHS Forth Valley 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.
- 4.11 The success of NHS Forth Valley anti-bribery measures depend on all employees, and those acting for NHS Forth Valley playing their part in helping to detect and eradicate bribery. Therefore, all employees and others acting for or on behalf of NHS Forth Valley are encouraged to report any suspected bribery (see sections 4.4 & 4.5 on ways of reporting).

5. Roles & responsibilities

- 5.1 Responsibility for receiving information relating to suspected frauds has been delegated to the Fraud Liaison Officer (FLO). This individual is responsible for informing third parties such as CFS, Internal Audit and External Audit or the Police (where appropriate) when suspicions of potential fraud are brought to their attention, either directly or indirectly. The Scheme of Delegation included as Annex D within the Standing Orders of the Board state that the Authorised Deputy FLO is the Director of Finance.
- 5.2 The FLO shall inform and consult the Chief Executive and/or Director of Finance in cases where the loss may be above the delegated limit or where the incident may lead to adverse publicity. The FLO will advise the Director of Finance on any potential referral to CFS. The roles and responsibilities of NHS Fraud Liaison Officers are set out within Annex B of CEL 11 (2013) Strategy to Combat Financial Crime in NHS Scotland' https://www.sehd.scot.nhs.uk/mels/CEL2013_11.pdf
- 5.3 Where a fraud is suspected within the service, including the Primary Care i.e., such as independent contractors providing Medical, Dental, Ophthalmic or Pharmaceutical Services, the FLO will make an initial assessment and, where appropriate, advise CFS.
- 5.4 The roles and responsibilities of the Board's nominated Counter Fraud Champion (CFC) are set out within https://www.sehd.scot.nhs.uk/mels/CEL2013_11.pdf
The contact details of the Counter Fraud Champion are included in the Key Contacts listed in Annex 1 below.
- 5.5 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.
- 5.6 Where the incident is thought to be subject to either local or national controversy and publicity then the Board and the Scottish Government Health and Social Care Directorates should be notified before the information is subjected to publicity. 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 publicise details about a suspected fraud/theft on Social Network Sites, blogs or Twitter. Employees must ensure that no action taken, could give rise to an action for slander or libel.

5.7 It is necessary to categorise the irregularity prior to determining the appropriate course of action. Two main categories exist:

- Theft, burglary, and isolated opportunist offences; and
- Fraud, corruption, and other financial irregularities.

5.8 The former will be dealt with directly by the Police whilst the latter may require disclosure under the SGHD NHS Circular No. [HDL \(2002\) 23](#) – Financial Control: Procedure where Criminal Offences are suspected.

RESPONSE PLAN

6. Introduction

6.1 The following sections describe NHS Forth Valley's intended response to a reported suspicion of theft, fraud or corruption. It is intended to provide procedures, which allow for gathering and collating evidence in a manner that will facilitate an 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.

7. Reporting theft, fraud and corruption

7.1 Where an NHS colleague is suspected of theft, fraud or corruption then it is imperative that advice is sought from HR at the earliest opportunity. However, in the first instance any suspicion of fraud, theft or corruption should be reported to the relevant Head of Department. If the suspected theft, fraud or corruption involves the Head of Department then any suspicion should be reported in writing to a more senior officer or directly to the FLO. The contact details for the Fraud Liaison Officer are shown in the Key Contacts listed in Annex 1 below.

7.2 Once a suspicion regarding an NHS colleague has been reported then it is essential that contact should be made with HR before proceeding with any internal investigation. This will allow senior HR officers and line managers to make any decision on potential suspension or Police involvement. It will also allow discussion and agreement between the Head of Department/senior officer and HR regarding formal referral of the suspicion to the FLO. Once an agreement is reached, the suspicion and the grounds for that suspicion should be submitted to the FLO. Where the suspicion relates to potential or actual fraud or corruption, information provided will be utilised by the FLO to populate a CFS1 form for formal referral of the matter to CFS who will consider the referral and take a view on whether a criminal investigation is justified.

7.3 For incidents involving Executive Directors of the Board, the FLO should contact the Chair of the Board or the Chair of the Audit Committee. It is important to act quickly when a suspicion is reported

in order to minimise further losses to the Board. This also allows action to be taken to secure evidence required for any future proceedings; criminal or disciplinary.

- 7.4 Where the subject of the suspected theft, fraud or corruption is not an NHS colleague then the suspicion should be reported in writing to the Head of Department. It is important to capture as much information as is readily available regarding the person (or persons) suspected of fraud, theft or corruption for reporting to the FLO. The Head of Department and the FLO will then discuss and agree the most appropriate way forward, which may or may not include reporting the matter to Police Scotland and/or CFS.
- 7.5 For all instances where fraud or corruption is suspected a “nominated officer” will be appointed as the main point of contact for all stakeholders. For NHS Forth Valley, this officer is the FLO (see paragraph 5.1 above). In the absence of the FLO, the Deputy FLO will deal with the issue. For incidents involving any Executive Directors of the Board the nominated officer will be the Board Chairman, contacted through the FLO. It is important to act quickly when suspicions are reported in order to minimise further losses to the Board and also to allow action to be taken to secure evidence required for any future disciplinary or criminal proceedings.
- 7.6 CEL 44 (2008) updated the required reporting standards in a revised SFR 18 (Scottish Financial Return). The SFR 18 forms part of the Board’s annual accounts and the change was to improve reporting of all relevant items. The FLO will maintain a log of any reported suspicions of fraud, theft or corruption. 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 utilised to help populate the Boards SFR 18.2 form which forms part of the Board’s annual accounts.
- 7.7 The nominated officer should consider the need to inform the NHS Forth Valley Board, the Chief Internal Auditor, External Audit, the Police and CFS, of the reported incident. In doing so, cognisance should be taken 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 Forth Valley may determine) or where the incident may lead to adverse publicity.
 - CFS should be informed immediately in all but the most trivial cases. This should be progressed via the FLO.
 - If fraud 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 that may alert suspects and precipitate the destruction or removal of evidence. This includes taking action to stop a loss or tighten controls.
 - If a criminal act is suspected, particularly fraud or corruption, it is essential that there is the earliest possible consultation with the Police. The Police 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. 4

7.8 All such contact should be formally recorded in the Log. It should be noted that staff who wish to raise concerns about unprofessional behaviour or decisions (where fraud, theft or corruption are not suspected) should do so by following the guidance contained in the NHS Forth Valley 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.

8. Managing the investigation

8.1 The decision on whether a referral is progressed by CFS as a criminal investigation is usually taken following correspondence between the FLO and CFS and usually involves an initial meeting to consider the available evidence. If the referral involves an employee of the Board then HR involvement in any initial meeting is crucial to avoid any conflict with ongoing or future disciplinary processes. Normally, the manager leading the investigation will be an employee from CFS. The circumstances of each case will dictate who will be involved and when.

8.2 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.

8.3 CFS staff, acting on behalf of the Director of Finance on any matters related to the investigation of fraud) are entitled without necessarily giving prior notice to require and receive:

- a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case he 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.

8.4 If after initial CFS enquiries it is determined that there are to be no criminal proceedings then an internal investigation by NHS Forth Valley may be more appropriate. In this instance, all information/evidence gathered by CFS will be passed to NHS Forth Valley. The internal investigation will then be taken forward as appropriate in line with Employment Law, PIN guidelines and relevant HR policies such as the Management of Employee Conduct Policy.

8.5 Any 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 required;
- 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 any recurrence.

8.6 Where the report confirms a criminal act and notification to the Police has not yet been made, then a formal report should be submitted to Police Scotland at that point.

8.7 Where recovery of a loss to NHS Forth Valley 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 (CLO), which provides legal advice and services to NHS Scotland.

8.8 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.

9. Disciplinary/dismissal procedures

9.1 Consideration should be made in conjunction with CFS/CFC/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 Forth Valley's Management of Employee Conduct Policy.

9.2 The disciplinary procedures of NHS Forth Valley have to be followed in any disciplinary action taken by NHS Forth Valley toward an employee (including dismissal). This may involve the person in charge of the investigation recommending a disciplinary hearing to consider the facts, reflect on the results of the investigation and recommendations on any further appropriate action, to the employee's line manager. Where the fraud involves a Primary Care Services Practitioner the Board should pass the matter over to the relevant professional body for action.

10. Gathering evidence

10.1 This policy cannot cover all the complexities of gathering evidence. Each case must be progressed based on the individual circumstances of the case, taking professional advice as necessary (including advice from CLO where deemed appropriate). Where CFS decides not to pursue a criminal investigation, for whatever reason, the recommended next steps may involve an internal, Board-level investigation. In these circumstances it is important that the gathering of evidence is carried out in a methodical and consistent way.

10.2 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 HR 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 his or her own words.

10.3 At all stages of the investigation, any discussions or interviews should be documented and where feasible agreed with the interviewee.

10.4 Physical evidence should be identified and gathered together in a secure place at the earliest opportunity. An inventory should be drawn up by the investigating officer and held with the

evidence. To prevent any changes being made to the original evidence, where possible, a replacement or alternative record should be implemented for business continuity. It is essential that the evidence is kept intact. 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.

11. Disclosure of loss from fraud

- 11.1 Guidance on the referring of losses and special payments is provided in [CEL 10 \(2010\)](#) – Revised Scottish Financial Return (SFR) 18: Enhanced Reporting of NHS Frauds and Attempted Frauds. This includes reporting of all forms of irregular activity which suggest that fraud may have taken place, even if the evidence is not of a standard that can be used for prosecution. Scottish Financial Return (SFR) 18.0 on Losses and Compensation Payments is submitted annually to the Audit Committee as part of the Annual Accounts. SFR 18 should include all losses, with appropriate description, aligned within the standard categories specified by the SGHSCD. External Audit should be notified of any loss as part of their statutory duties.
- 11.2 Management must take account of the permitted limits on writing off losses for “Category 2 Boards”, as outlined in [Annex C of CEL 10 \(2010\)](#).

12. Police Involvement

- 12.1 It shall normally be the policy of NHS Forth Valley that, wherever a criminal act 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.
 - Outwith normal working hours, the manager on duty in the area where a criminal act is suspected should always report the matter to the Senior Manager and Executive Director On Call. It will be the decision of the Executive Director On Call as to the stage that the Police are contacted. In any case the manager on duty in the area where a criminal act is suspected should always report the matter to the Director of Finance and the FLO at the earliest possible time.
- 12.2 The nominated officer 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.
- 12.3 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.

13. Press Release

- 13.1 To avoid potentially damaging publicity to the NHS and/or the suspect, NHS Forth Valley 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. The Communications Team within CFS, the CLO and the Police should agree the release where applicable.

- 13.2 Under no circumstances should a member of staff speak or write to representatives of the press, TV or radio, about a suspected fraud without the express authority of the Chief Executive.
- 13.3 The Officer in Charge of the criminal case, whether from CFS or Police Scotland, will be responsible for collaborating with the Board's communications department in relation to preparing and agreeing the timing and content of an appropriate press release.

14. Resourcing any internal investigation

- 14.1 The Director of Finance will determine the type and level of resource to be used in investigating any suspected fraud. The choices available will include:
- Staff from within NHS Forth Valley
 - Internal Audit
 - Specialist Consultant
 - Police
- 14.2 In deciding, the Director of 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 Nominated Officer. A decision to take "No action" will not normally be an acceptable option unless exceptional circumstances apply.
- 14.3 In any case involving a suspected criminal act, it is anticipated that CFS involvement will be in addition to NHS Forth Valley resources. In any case involving other suspected criminal acts, it is anticipated that Police involvement will be in addition to NHS Forth Valley resources.

15. The law and its remedies

- 15.1 Criminal Law - The Board shall refer all incidences of suspected fraud/criminal acts to CFS or the Police for decision by the Procurator Fiscal as to any prosecution.
- 15.2 Civil Law - The Board shall refer all incidences of loss through proven fraud/criminal act to the CLO for opinion, as to potential recovery of loss via Civil Law action.

Annex 1 – Key Contacts

Board Key Contacts

Role	Name	Designation	Contact Details
Fraud Liaison Officer	Shona Slayford	Principal Auditor	01592 226904 shona.slayford@nhs.scot
Deputy Fraud Liaison Officer	Scott Urquhart	Director of Finance	01786 457245 scott.urquhart@nhs.scot
Counter Fraud Champion	Robert Clark	Non-Executive Member and Employee Director	01786 457226 robert.clark4@nhs.scot
Whistleblowing Champion	Gordon Johnston	Non-Executive Member and Whistleblowing Champion	gordon.johnston@nhs.scot

External Contacts

Counter Fraud Hotline – 08000 15 16 28

National Confidential Alert Line for NHS Scotland employees - 0800 0086112

Independent National Whistleblowing Officer - 0800 008 6112

<https://inwo.spsa.org.uk/whistleblowing>

SECTION E

Standing Financial Instructions

SECTION 1 INTRODUCTION

1.1 GENERAL

- 1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the National Health Service (Financial Provisions) (Scotland) Regulations, 1974, Section 4 together with the subsequent guidance and requirements contained in NHS Circular No.1974 (GEN) 88 and Annex for the regulation of the conduct of Forth Valley NHS Board, its directors, officers, and agents in relation to all financial matters. Those regulations are the Health Boards (Membership and Procedure) Regulations 2001. Forth Valley Health Board is the common name of Forth Valley NHS Board. The Board's formal, legal title remains Forth Valley NHS Board and it will be identified as such in certain legal and financial documents. These SFIs are also issued in accordance with NHS MEL (1994) 80 and the guidance in 'Rebuilding Our National Health Service - A Change Programme For Implementing Our National Health' and they shall have the effect as if incorporated in the Standing Orders of Forth Valley NHS Board.
- 1.1.2 These SFIs detail the financial responsibilities, policies, and procedures to be adopted by Forth Valley NHS Board. They are designed to ensure that Forth Valley NHS Board financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency, and effectiveness. They should also be used in conjunction with the Scheme of Delegation adopted by the Board.
- 1.1.3 These SFIs identify the financial responsibilities, which apply to everyone working for the Board and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and Financial Operating Procedures. The Director of Finance must approve all Financial Operating Procedures.
- 1.1.4 Statutory Instrument (1974) No.468 requires Directors of Finance to design, implement and supervise systems of financial control and NHS circular 1974 (GEN) 88 requires the Director of Finance to:
- (a) approve the financial systems
 - (b) approve the duties of officers operating these systems
 - (c) maintain a written description of such approved financial systems, including a list of specific duties
- 1.1.5 Should any difficulties arise regarding the interpretation or application of any of the SFI's then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the Provisions of the Board's Standing Orders.
- 1.1.6 Failure to comply with SFIs is a disciplinary matter, which could result in dismissal.

1.2 TERMINOLOGY

- 1.2.1 Any expression to which a meaning is given in Health Service Acts, or in directions made under the Acts, shall have the same meaning in these instructions; and:

- (a) "Board" means the Board of Forth Valley NHS Board or such Committee of the Board to which powers have been delegated
- (b) "Budget" means an allocation of resources, expressed in financial terms, proposed by Forth Valley NHS Board for the purpose of carrying out, for a specific period, any, or all of the functions of Forth Valley NHS Board
- (c) "Chief Executive" means the chief officer of Forth Valley NHS Board and who is directly accountable to the Board
- (d) "Director of Finance" means the chief financial officer of Forth Valley NHS Board
- (e) "Budget Holder" means the director or officer of Forth Valley NHS Board who has the delegated authority to manage finances (income and expenditure) for a specific operational area of Forth Valley NHS Board
- (f) "Legal Adviser" means the properly qualified person appointed by Forth Valley NHS Board to provide legal advice.

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

1.2.3 References in these instructions to "officer" shall be deemed to include all employees of Forth Valley NHS Board, including nursing and medical staff, and consultants who practice upon Forth Valley NHS Board premises, as well as the staff of any agency contracted to Forth Valley NHS Board and/or performing financial functions on behalf of Forth Valley NHS Board.

1.2.4 All references in these SFIs to the masculine gender shall be read as equally applicable to the feminine gender.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board shall exercise financial supervision and control by:

- (a) requiring the submission and approval of financial plans and budgets within approved allocations/overall income to a pre-determined timetable
- (b) defining and approving essential features of financial arrangements in respect of important procedures and financial systems (including the need to obtain value for money)
- (c) defining specific responsibilities placed on directors and officers as indicated in the Scheme of Delegation document

1.3.2 Within the Instructions it is acknowledged that the Chief Executive and Director of Finance shall have joint responsibility for ensuring that the Board meets its obligation to perform its functions within the financial resources available. The Chief Executive has overall responsibility for the Board's activities and is responsible to the Board for ensuring containment within the Board's Revenue Resource Limit, Capital Resource Limit and Cash Limit.

1.3.3 The Chief Executive's responsibilities as Accountable Officer are set out in Section 2.

1.3.4 The Chief Executives of the NHS Health Boards have retained Accountable Officer Status under NHS arrangements.

- 1.3.5 The Chief Executive is ultimately accountable to Forth Valley NHS Board and as Accountable Officer to the Scottish Parliament for ensuring that the Forth Valley NHS Board meets its obligations to perform its functions within the available resources.
- 1.3.6 Forth Valley NHS Board shall delegate executive responsibility for the performance of its functions to the Chief Executive and to the senior management team. Members will exercise financial supervision and control by requiring the submission and approval of financial plans within approved allocations, by defining and approving essential features of financial arrangements in respect of important procedures and financial systems, including the need to obtain value for money and by defining specific responsibilities placed on our officers.
- 1.3.7 So far as is possible, the Chief Executive and Director of Finance will delegate their detailed responsibilities but retain their overall accountability. The extent of delegation will be kept under review by the NHS Board.
- 1.3.8 It is the duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these SFIs.
- 1.3.9 Without prejudice to any other functions of officers of Forth Valley NHS Board, the Director of Finance shall be responsible for:
- (a) provision of financial advice to the Board and its officers
 - (b) setting the Board's accounting policies consistent with Scottish Government and Treasury guidance and generally accepted accounting practice
 - (c) supervising the implementation of the Board's financial strategies and for co-ordinating any corrective action necessary to further these strategies
 - (d) ensuring that sufficient records are maintained to show and explain Forth Valley NHS Board transactions, in order to disclose, with reasonable accuracy, the financial position of Forth Valley NHS Board at any time
 - (e) the design, implementation, and supervision of systems of financial control incorporating the principles of separation of duties and internal checks
 - (f) the 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 and responsibilities
- 1.3.10 All directors and officers of Forth Valley NHS Board, severally and collectively, are responsible for:
- (a) the security of Forth Valley NHS Board property
 - (b) avoiding loss
 - (c) exercising economy and efficiency in the use of Forth Valley NHS Board resources; complying with the requirements of:
 - Standing Orders (including the Scheme of Delegation)
 - Standing Financial Instructions
 - Financial Operating Procedures
 - MEL (1994) 48 Standards of Business Conduct for Staff which will be identified in the Staff Handbook

- 1.3.11 The form in which financial records are kept and the manner in which duties are discharged by all directors and officers of Forth Valley NHS Board who carry out a financial function must be to the satisfaction of the Director of Finance.
- 1.3.12 Any contractor, agent or employee of a contractor who is empowered by Forth Valley NHS Board to commit Forth Valley NHS Board to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

SECTION 2 RESPONSIBILITIES OF HEALTH BOARD CHIEF EXECUTIVE AS ACCOUNTABLE OFFICER

2.1 INTRODUCTION

- 2.1.1 Under the terms of Section 14 and 15 of the Public Finance and Accountability (Scotland) Act 2000, the Principal Accounting Officer for the Scottish Government has designated the Chief Executive of Forth Valley NHS Board as Accountable Officer.
- 2.1.2 Accountable Officers must comply with the terms of the Memorandum to National Health Service Accountable Officers, and any updates issued to them by the Principal Accountable officer for the Scottish Government. The Memorandum was updated in April 2002.

2.2 GENERAL RESPONSIBILITIES

- 2.2.1 The Accountable Officer is personally answerable to the Scottish Parliament for the propriety and regularity of the public finances for NHS Forth Valley. The Accountable Officer must ensure that the Forth Valley NHS Board takes account of all relevant financial considerations, including any issues of propriety, regularity, or value for money, in considering policy proposals relating to expenditure, or income.
- 2.2.2 It is incumbent upon the Accountable Officer to combine his/her duties as Accountable Officer with their duty to the Forth Valley NHS Board, to whom he/she is responsible, and from whom he/she derives his/her authority. The Forth Valley NHS Board is in turn responsible to the Scottish Parliament in respect of its policies, actions, and conduct.
- 2.2.3 The Accountable Officer has a personal duty of signing the Annual Accounts of Forth Valley NHS Board for which he/she has responsibility. Consequently, he/she may also have the further duty of being a witness before the Audit Committee of the Scottish Parliament and be expected to deal with questions arising from the Accounts, or, more commonly, from reports made to Parliament by the Auditor General for Scotland.
- 2.2.4 The Accountable Officer must ensure that any arrangements for delegation promote good management, and that he/she is supported by the necessary staff with an appropriate balance of skills. This requires careful selection and development of staff and the sufficient provision of special skills and services. He/she must ensure that staff are as conscientious in their approach to costs not borne directly by their component organisation (such as costs incurred by other public bodies, or financing costs, e.g., relating to banking and cash flow) as they would be where such costs directly borne.

2.3 SPECIFIC RESPONSIBILITIES

2.3.1 The Accountable Officer must:

- (a) ensure that from the outset, proper financial systems are in place and applied, and that procedures and controls are reviewed from time to time to ensure their continuing relevance and reliability, especially at times of major changes

- (b) sign the Accounts assigned to him/her, and in doing so accept personal responsibility for ensuring that they are prepared under the principles and in the format directed by Scottish Ministers
- (c) ensure that proper financial procedures are followed incorporating the principles of separation of duties and internal check, and that accounting records are maintained in a form suited to the requirements of the relevant Accounting Manual, as well as in the form prescribed for published Accounts
- (d) ensure that the public funds for which he/she is responsible are properly managed and safeguarded, with independent and effective checks of cash balances in the hands of any official
- (e) ensure that the assets for which he/she is responsible, such as land, buildings, or other property, including stores and equipment, are controlled, and safeguarded with similar care, and with checks as appropriate
- (f) ensure that, in the consideration of policy proposals relating to expenditure, or income, for which he/she has responsibilities as Accountable Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are considered, and where necessary brought to the attention of the Board
- (g) ensure that any delegation of authority is accompanied by clear lines of control and accountability, together with reporting arrangements
- (h) ensure that effective management systems appropriate for the achievement of the organisation's objectives, including financial monitoring and control systems have been put in place
- (i) ensure that risks, whether to achievement of business objectives, regularity, propriety, or value for money, are identified, that their significance is assessed and that systems appropriate to the risks are in place in all areas to manage them
- (j) ensure that best value from resources is sought, by making proper arrangements to pursue continuous improvement having regard to economy, efficiency, and effectiveness, and in a manner, which encourages the observance of equal opportunities requirements
- (k) ensure that managers at all levels have a clear view of their objectives, and the means to assess and measure outputs or performance in relation to these objectives
- (l) ensure managers at all levels are assigned well defined responsibilities for making the best use of resources (both those assumed by their own commands and any made available to organisations or individuals outside NHS Forth Valley) including a critical scrutiny of output and value for money
- (m) ensure that managers at all levels have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively

2.4 REGULARITY AND PROPRIETY OF EXPENDITURE

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

SECTION 3 ALLOCATIONS, BUSINESS PLANNING, BUDGETS AND BUDGETARY CONTROL

3.1 GENERAL

- 3.1.1 The Board is required by statutory provisions made under Section 85 of the National Health Service (Scotland) Act (1978), as amended by the Health Services Act 1980, to perform its functions within the total funds allocated by the Scottish Ministers. All plans and financial approval systems shall be designed to meet this obligation.

3.2 ALLOCATIONS

- 3.2.1 The Director of Finance of the Board will review, as a minimum annually, the bases and assumptions used for distributing allocations to ensure such allocations are fair, realistic and secure the Board's entitlement to funds.

3.3 BUSINESS PLANNING AND BUDGETS

- 3.3.1 The Chief Executive will prepare and submit to the board the Annual Operational Plan and an Annual Plan. This Plan shall include forecasts of available resources, financial targets and spending proposals.
- 3.3.2 The Director of Finance shall, on behalf of the Chief Executive, prepare and submit to the Board for its approval, an annual financial plan for all revenue funds and capital where applicable, within the limits of available funds as determined by the notified allocations.
- 3.3.3 The Director of Finance shall ensure such plans are reconcilable to budgets that have been produced following discussion with General Managers, Chief Officers, Acute Services Director and Executive Directors. As a consequence, the Director of Finance shall have right of access to all budget holders on budgetary related matters.

3.4 BUDGETARY CONTROL

- 3.4.1 The Board shall delegate the management of the Financial Plan to the Chief Executive. The Chief Executive within limits approved by the Board, can delegate responsibility for a budget or part of a budget to individual Senior Managers. The terms of delegation shall include, in writing, a clear definition of individual responsibilities for control of expenditure, exercise of virement, achievement of performance levels and the provision of regular reports on the discharge of these delegated functions. The delivery of this delegation shall be included within the performance review of appropriate officers.
- 3.4.2 In performance of their duties:
- (a) The Chief Executive will not exceed the budgetary or virement limits or exclusions set by

the Board or by the Scottish Government Health and Social Care Directorate.

- (b) Senior Managers will not exceed the budgetary or virement limits set by the Board and Chief Executive.
- (c) The Chief Executive may exercise virement or vary the budgetary limit of a Senior Manager within the Chief Executives own budgetary limit.

3.4.3 The Board shall approve and review annually a Scheme of Delegation that will form part of the Standing Orders of the Board. The Scheme of Delegation shall specify: -

- (a) areas of responsibility
- (b) nominated officers
- (c) financial value
- (d) virement levels

3.4.4 Expenditure for which no provision has been made in approved plans and budgets and outwith delegated virement limits may only be incurred after authorisation by the Chief Executive or the Director of Finance acting on their behalf, or the NHS Board dependent on the nature and level of expenditure. There shall be a financial limit of £500,000 in respect of the delegated authority of the Chief Executive on a non-recurring basis (No individual item shall exceed £100,000). The Director of Finance shall have authority within the Chief Executive's limit of £250,000.

3.4.5 The Director of Finance, on behalf of the Chief Executive, shall monitor the financial performance against the plan, the use of delegated budgets to ensure that financial control is maintained, and that the Board's plans and policies are implemented.

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

3.4.7 The Director of Finance shall ensure that:

- (a) the system of internal financial controls is sufficient and adequate to ensure the achievement of objectives and compliance with standards and regulations.
- (b) adequate statistical and financial systems are in place to monitor and control all agreements for patients' services and facilitate the compilation of estimates, forecasts and investigations as may be required.
- (c) reports provide all financial, statistical, and other relevant information as necessary for the compilation of estimates and forecasts.
- (d) the Chief Executive and the Board are informed of the financial consequences of changes

in policy, pay awards and other events and trends affecting budgets or projections and shall advise on the financial and economic aspects of future plans and projects.

- (e) the issue of timely, accurate and comprehensible advice, and monthly financial reports to each budget holder, covering the areas for which they are responsible.

3.4.8 The Director of Finance shall provide the Board with regular reports including as follows: -

- (a) monthly financial reports for all expenditure to the Board in an approved format, inclusive of:
 - income and expenditure to date and forecast year-end position
 - movements in working capital
 - capital project spend and projected outturn against plan
 - explanation of significant variances from plan plus corrective action if appropriate, including an assessment as to whether such actions are sufficient to correct the situation
 - monitoring of management action to correct variances
 - cash spending to date and forecast year-end position
 - report on budgetary transfers
 - Board financial position including projections

3.5 ALIGNED AND POOLED BUDGETS

3.5.1 Partnership arrangements have been developing to give Health Boards and Local Authorities the flexibility to be able to work with other agencies to respond effectively to improve services, either by joining up existing services, or developing new, co-ordinated services. Such partnership arrangements provide for aligned and pooled budgets. Areas covered by Health and Social care Integration are contained in Section 4.

3.5.2 An Aligned Budget is the position when clearly identified financial resources are being used jointly. The funds are identified by the partner organisations and grouped together in a joint “pot”, but the funds are still technically held within each partner organisation in separate distinct budgets. This enables each partner organisation to identify and account for their own contribution to the joint “pot”.

3.5.3 A Pooled Budget is a mechanism by which each partner to the agreement contributes funding to form a discrete “fund” for the partnership arrangement or organisation. Initially, the funding contributed by each partner will be identifiable to each partner, but in time the origin of individual contributions may become less easily identifiable. The partners must therefore agree at the outset the purpose, scope and outcome for services within the agreement meeting their own statutory obligations and justifying their contribution to the fund. A Pooled Budget resides in a “host” partner, either a Health Board or a Local Authority organisation, which manages it on behalf of the partners.

3.5.4 Partnership arrangements entered into by Forth Valley NHS Board must comply with the guidance on aligned and pooled budgets issued by the Scottish Government. The following paragraphs relate mainly to Aligned Budgets (as opposed to Pooled Budgets).

- 3.5.5 As a non-statutory body, the responsibility for the functions carried out by a partnership body will remain with each partner organisation.
- 3.5.6 A Partnership Agreement or Heads of Agreement must be drawn up between the partner organisations which will specify the services to be managed jointly, the governance arrangements, the accountability arrangements, the budgetary control arrangements and the financial reporting and monitoring arrangements. The partnership agreement must be approved by the Director of Finance of each partner organisation before budgetary control can be devolved to a partnership body.
- 3.5.7 Each partner will agree the level of its contribution in advance of each financial year. The level of contribution from the Board will be agreed by the Board taking account of the need to balance the amount of flexibility that Forth Valley NHS Board want to enable through the aligned budget against the risk of being able to fulfil all service needs. Levels of contribution will have to allow, among other things, for decisions about inflation levels, developments, service pressures, Corporate Plan priorities, capital charges and savings targets.
- 3.5.8 The contribution to the Aligned Budget must be used on the agreed services set out in the partnership agreement. The aligned budget will be discrete and will be ring-fenced to the extent specified in the partnership agreement. The Partnership Agreement must also specify the mechanism for changing in-year levels of contribution.
- 3.5.9 Accountability will be discharged at two levels in Aligned Budget arrangements, i.e., within the partnership body, and to the Boards or Management Committees of each partner organisation.
- 3.5.10 Each partnership body will appoint a lead officer who will be accountable to the relevant Partnership Board for the combined budget.
- 3.5.11 The Chief Executive will remain accountable to the Scottish Government for the financial contribution made by their organisation.
- 3.5.12 Partnership bodies will be subject to both financial and value for money audit by both Internal Audit and the Auditor General for Scotland.
- 3.5.13 A Memorandum Income and Expenditure Account may require to be included in the Annual Accounts for Aligned Budget arrangements which show income received, expenditure incurred and the remaining surplus or deficit for the financial year.
- 3.5.14 The lead officer of the partnership body shall prepare a Constitution which will set out compliance with the Codes of Conduct, Accountability and Practice on Openness and the underlying principles of good Corporate Governance as set out in the Cadbury and Nolan Reports and the detailed guidance issued by the Scottish Government and others.
- 3.5.15 The lead officer of the partnership body shall issue Financial Regulations consistent with the SFIs in order to regulate the conduct of the Partnership Board, both members and officers, in all financial matters. Such regulations and instructions will specify the arrangements for the provision of financial advice to the Partnership Board.

- 3.5.16 The partnership body's Constitution and Financial Regulations shall be agreed by the Forth Valley NHS Board and shall have the effect as if incorporated in the Standing Orders and SFIs of the Board.
- 3.5.17 The above instructions will equally apply to new formal partnership arrangements with Local Authorities which the Board may develop in future years.

SECTION 4 HEALTH AND SOCIAL CARE INTEGRATION

4.1 GENERAL

- 4.1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 established the framework for the integration of adult health and social care services in Scotland. Two Integrated Joint Boards (IJBs) have been established in Forth Valley under the body corporate arrangement. The approved Integration Schemes set out the detail of the integration arrangement, including those services delegated by NHS Forth Valley to the IJBs.

4.2 FINANCIAL ARRANGEMENTS

- 4.2.1 Each partner will agree the formal budget setting timelines and reporting periods as defined in the Financial Regulations.
- 4.2.2 The initial budget for the NHS contribution to the Integrated Joint Board budget for delegated functions under the Public Bodies (Joint Working) (Scotland) Act 2014 will be set in accordance with the Integration Schemes and the due diligence process as described in the Scottish Government Integrated Resource Advisory group guidance.
- 4.2.3 In subsequent financial years the NHS Board will evaluate the case for the Integrated Budget against its other priorities and will agree its contributions accordingly. The business case put forward by the IJB will be evidenced based and will detail assumptions made.
- 4.2.4 Following on from the budget process, the IJB Chief Officer and Chief Financial Officer will prepare a financial plan supporting the Strategic Plan and once approved by the IJB issue Directions with defined payment levels to the NHS Board. 'Payment' does not mean an actual cash transaction but a representative allocation for the delivery of Integration Functions in accordance with the Strategic Plan.
- 4.2.5 If at the outset the NHS Board does not believe the direction can be achieved for the payment being offered, then it shall notify the IJB that in line with section 28 (4) of the Public Bodies (Joint Working) (Scotland) Act 2014 additional funding would be necessary to comply with the direction.
- 4.2.6 Once the payments to be made by the IJB to the NHS Board for the delegated functions have been agreed they will, for the directly managed functions, form the basis of annual budgets to be issued to the relevant budget holder. The payments for the set aside budgets will form part of the budgets to be issued to the relevant NHS budget holder.
- 4.2.7 Where the Chief Officer is the budget holder, they will comply with these SFIs unless the SFIs explicitly state otherwise. In further delegating budgetary authority to managers in their structure the Chief Officer is responsible for ensuring all transactions processed by the NHS comply with these SFIs and any further detailed procedural NHS Board guidance relevant to the transaction.
- 4.2.8 It is envisaged that the Chief Officer, in due course, will have a structure including joint management posts who are responsible for both Health and Council expenditure.

4.3 DELEGATED AUTHORITY

- 4.3.1 Where a manager has delegated authority for both health and council expenditure, they must ensure the VAT treatment is in line with the Integrated Resource Advisory Group and any HMRC guidance. If in doubt they should seek advice from the Director of Finance for any expenditure that might previously have been made from NHS budgets.
- 4.3.2 Where a council employee has been given delegated authority for NHS budgets a signed declaration that they have received and will comply with these SFIs is required. This should also be signed by the Chief Officer, who will further undertake to pursue any breaches of the NHS SFIs through the council line management structure if required.
- 4.3.3 The arrangements for the virement of budgets are specified in the scheme of delegation of the Parties and virement levels will be agreed in the Strategic Plan.
- 4.3.4 Notwithstanding that a budget virement lies within the Chief Officers level of authority it can only be executed if detailed consideration of the financial impact confirms any risks associated with it are acceptable. If there is a difference of opinion between the Chief Officer and NHS finance as to the acceptability of the risk, the Chief Officer and Director of Finance of the NHS will first seek to reach an acceptable solution. Failing that the Chief Executive of the NHS will consider the level of risk, involving the SLT if necessary, for a wider view. Should there still not be agreement the IJB would be invited to review this and set out how it would mitigate the stated risk.
- 4.3.5 In managing these operational budgets, the Chief Officer will comply with these SFIs unless the SFIs explicitly state otherwise.

4.4 MANAGEMENT OF IN YEAR VARIANCES

- 4.4.1 Where there is a projected overspend against an element of the Integrated Budget, the Chief Officer, the Chief Finance Officer of the IJB and the relevant finance officer and operational manager of the constituent party must agree a recovery plan to balance the overspending budget.
- 4.4.2 Underspends on either arm of the Integrated Budget should be returned from the relevant Party to the IJB and carried forward through the reserves. This will require adjustments to the allocations from the IJB to the relevant Party for the sum of the underspend.

4.5 FINANCIAL MANAGEMENT AND REPORTING ARRANGEMENTS

- 4.5.1 The NHS Director of Finance is responsible for providing the Chief Officer (as with all budget holders) with regular financial information to allow them to manage their budgets. The NHS Director of Finance is also responsible for providing the Chief finance officer of the IJB with the financial information required by the integration scheme as expanded by subsequent agreements, to meet the reporting requirement to the IJB. In advance of each financial year a

timetable will be agreed with the IJB.

- 4.5.2 The IJB Chief Financial Officer will be responsible for the preparation of the annual financial statements as required by section 39 of the Public Bodies (Joint Working) (Scotland) Act 2014 and the statutory annual accounts. The Accounting Standards as adapted for the public sector will apply to the Integration Joint Board. The Code of Practice on Local Authority Accounting in the UK will be the applicable guidance for their interpretation. The financial statements of the Integration Joint Board will be completed to meet the audit and publication timetable specified in regulations (Regulations under section 105 of the Local Government (Scotland) Act 1973). Although the responsibility lies with the Chief Finance Officer of the IJB the Director of Finance will ensure such information is supplied from the NHS as is required to fulfil these obligations.
- 4.5.3 The financial ledger transactions relating to the Integration Joint Board will be carried out prior to the end of the financial year with post year-end adjustments for material information only. Year-end balances and transactions will be agreed timeously in order to allow completion of the Accounts in line with required timescales. This date will be agreed annually by the Integration Joint Board, the Health Board and the Local Authority.
- 4.5.4 Detailed Financial Regulations governing the Integration Joint Board will be agreed between the Local Authority and the Health Board and approved by the Integration Joint Board. Once agreed the NHS Director of Finance will be responsible for ensuring any NHS obligations are fulfilled.
- 4.5.5 Although the Public Bodies (Joint Working) (Scotland) Act 2014 will supersede most of the previous joint working arrangements, it remains possible that there could be pooled or aligned budgets with community partners, such as for children's services, that fall outwith that. Section 3 has therefore been retained in case they should be required.

SECTION 5 COMMISSIONING OF HEALTHCARE

5.1 FINANCIAL TARGETS

- 5.1.1 The Scottish Government sets 3 budget limits at a Health Board level on an annual basis. These limits are:
- (a) Revenue Resource Limit: a resource budget for ongoing operations
 - (b) Capital Resource Limit: a resource budget for net capital investment
 - (c) Cash requirement: a financing requirement to fund the cash consequences of the ongoing operations and net capital investment
- 5.1.2 Health Boards are required to contain their net expenditure within these limits and will report on any variation from the limits as set.
- 5.1.3 The Director of Finance shall be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Board to fulfil its statutory responsibility while achieving its financial targets.

5.2 GENERAL - HEALTH NEEDS ASSESSMENT

- 5.2.1 The Director of Public Health, on behalf of the Chief Executive is responsible for the production of Health Needs Assessments, and for the monitoring of Health Status.
- 5.2.2 The Health Needs Assessment Reports incorporate historical and projected financial information. The Director of Finance is responsible for the provision of historical financial details and for the financial impact/implication of each Needs Assessment.

5.3 GENERAL - HEALTH PLANNING

- 5.3.1 The Chief Executive is responsible for the production of the Corporate Plan (Healthcare Strategy). The Corporate Plan will be informed amongst others by
- (a) plans arising from Health Needs Assessments
 - (b) socio-demographic trends
 - (c) public opinion
 - (d) resource availability
 - (e) Business unit pressures
- 5.3.2 To prepare health strategies or develop plans for individual care groups or service areas, planning groups may be established. The Director of Finance has responsibility for ensuring that where appropriate the remit of such groups outlines the financial parameters within which the group may operate. On occasion these groups may also cover Local Authority services. In this

instance the parameters should be agreed with the appropriate individuals within Local Authorities.

- 5.3.3 The Director of Finance is responsible for the provision of financial advice and plans in respect of the affordability of the Corporate Plan.

5.4 PRIMARY HEALTH CARE

- 5.4.1 Primary Health Care Services include:

- (a) all Family Practitioner Services
- (b) Practice Staff
- (c) Primary Health Care Computing
- (d) Cost Rent and Improvement Grant Schemes

- 5.4.2 Primary Health Care Services fall within the scope of Integration Authorities. Resources are allocated from the Integration Authority via direction in line with the Strategic Plans. Any variations proposed to budgets must be approved by the Director of Finance of Forth Valley NHS Board.

5.5 COMMUNITY SERVICES

- 5.5.1 Community Services include

- (a) mental health (inclusive of elderly, frail elderly, long-stay and community)
- (b) learning disability
- (c) palliative hospice care
- (d) community health services
- (e) drugs and alcohol
- (f) healthcare in prisons

- 5.5.2 Local Community Health Care Services are managed by either the Chief Officers or a General Manager. Resources managed by the Chief Officers fall within the scope of Integration Authorities. Resources managed by the General Manager may fall within the scope of Integration Authorities. Resources are allocated from the Integration Authority via direction in line with the Strategic Plans. Any variations proposed to budgets must be approved by the Director of Finance of Forth Valley NHS Board.

Resources are managed by the General Manager which do not fall within the scope of Integration Authorities. Resources are transferred on a monthly basis in accordance with the annual

financial plan and any subsequent agreed variations. Such variations must be signed by the Director of Finance of Forth Valley NHS Board.

- 5.5.3 NHS Boards outwith the Forth Valley area may also provide these services to local residents. In such instances service agreements will be prepared. Resources are transferred on a monthly basis in accordance with the annual financial plan and any subsequent agreed variations. Such variations must be signed by both the Director of Finance of the Forth Valley NHS Board and the Director of Finance of the appropriate Health Board.

5.6 INPATIENT AND OTHER SERVICES

- 5.6.1 These include:

- (a) Emergency and urgent care
- (b) Acute inpatients and Community Hospital beds
- (c) Ambulatory Care and Day Surgery
- (d) Outpatient Services
- (e) Cancer Services
- (f) Allied Health Professionals
- (g) Diagnostic Services
- (h) Women and Children Services

- 5.6.2 Local Acute Services are managed by the relevant General Manager. Resources managed by the General Manager may fall within the scope of Integration Authorities. Resources are allocated from the Integration Authority via direction in line with the Strategic Plans. Any variations proposed to budgets must be approved by the Director of Finance of Forth Valley NHS Board.

Resources are managed by the General Manager which do not fall within the scope of Integration Authorities. Resources are transferred on a monthly basis in accordance with the annual financial plan and any subsequent agreed variations. Such variations must be signed by the Director of Finance of Forth Valley NHS Board.

- 5.6.3 NHS Boards outwith the Forth Valley area may also provide these services to local residents. In such instances service agreements will be prepared. Resources are transferred on a monthly basis in accordance with the annual financial plan and any subsequent agreed variations. Such variations must be signed by both the Director of Finance of the Forth Valley NHS Board and the Director of Finance of the appropriate Health Board.

SECTION 6 BANKING AND INVESTMENTS

6.1 INTRODUCTION

- 6.1.1 The Director of Finance is responsible for managing Forth Valley NHS Board banking arrangements and for advising Forth Valley NHS Board on the provision of banking services and the operation of bank accounts. This advice will take into account such guidance and directions as may be issued by the Scottish Government Health and Social Care Directorate.

6.2 BANK ACCOUNTS

- 6.2.1 The Director of Finance is responsible for:
- (a) Establishing exchequer bank accounts as directed by Scottish Government Health and Social Care Directorate
 - (b) establishing separate bank accounts for Forth Valley NHS Board non exchequer funds
 - (c) ensuring payments made from accounts do not exceed the amount credited to the account except where arrangements have been made
 - (d) reporting to the Board all arrangements made with Forth Valley NHS Board bankers for accounts to be overdrawn
- 6.2.2 All funds shall be held in accounts in the name of Forth Valley NHS Board. No officer other than the Director of Finance plus one other signatory shall open or close any bank account in the name of Forth Valley NHS Board.
- 6.2.3 The Director of Finance will advise the Bankers in writing of the conditions under which each account shall be operated.

6.3 BANKING PROCEDURES

- 6.3.1 The Director of Finance shall prepare procedural instructions on the operation of accounts. These instructions must include:
- (a) the conditions under which each account is to be operated
 - (b) the limit to be applied to any overdraft
 - (c) those authorised to sign cheques or other payments on Forth Valley NHS Board accounts
- 6.3.2 The Director of Finance shall ensure appropriate arrangements are in place for the use of debit/credit card transactions.
- 6.3.3 An authorised signatory shall advise the bankers of the officers authorised to release money from or make electronic payment from each bank account.
- 6.3.4 An authorised signatory shall notify the bankers promptly of the cancellation of any authorisation to draw on Forth Valley NHS Board accounts

- 6.3.5 Where an agreement is entered into with a Health Board or other body for payment to be made on behalf of Forth Valley NHS Board from bank accounts maintained in the name of that Health Board or other body, or by electronic funds transfer (BACS), the Director of Finance shall ensure that satisfactory security regulations of the Health Board or other body relating to any such accounts exist and are observed.

6.4 INVESTMENTS

- 6.4.1 Temporary cash surpluses shall be held only in accordance with SGHSCD guidance.
- 6.4.2 All balances remain within National accounts with required amounts transferred to the commercial bank accounts as required.
- 6.4.3 In accordance with HDL (2001) 49 the amount of working cash held in commercial bank accounts at Board level should be limited to no more than £50,000. Any excess funds available at Board level sit in the NatWest Account.

SECTION 7 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

7.1 CAPITAL INVESTMENT

- 7.1.1 The overall control of all capital investment and fixed assets shall be the responsibility of the Chief Executive, advised by the Director of Finance and Director of Facilities and Infrastructure.
- 7.1.2 Whilst the Board reserves decision making with regard to the Five Year Capital Plan and the Annual Capital Plan, the Chief Executive:
- (a) shall ensure that there is an adequate appraisal and approval process in place for determining capital investment priorities and the effect of each proposal on the Board Health Strategy and Annual Plan in accordance with the guidance contained in the Scottish Capital Investment Manual (SCIM)
 - (b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost
 - (c) will ensure that capital investment is not undertaken without confirmation of the availability of resources to finance all revenue consequences
- 7.1.3 The Chief Executive will also ensure that, for every capital expenditure proposal:
- (a) where required, a business case is prepared setting out an option appraisal of potential benefits compared with known costs to determine the option with the most favourable ratio of benefits to costs in accordance with the guidance contained in the Scottish Capital Investment Manual (SCIM)
 - (b) the Director of Finance has certified professionally to the costs and revenue consequences
 - (c) appropriate project management and control arrangements are set in place
- 7.1.4 On approval of a capital investment scheme in accordance with the Scheme of Delegation, the Director of Finance shall issue the following to the manager responsible for the capital investment project:
- (a) specific authority to commit expenditure
 - (b) authority to proceed to tender
 - (c) authority to accept a successful tender
- 7.1.5 The Director of Finance shall ensure that procedures are in place for the regular reporting of actual expenditure against authorisation of capital expenditure.

- 7.1.6 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the Scottish Capital Investment Manual (SCIM).
- 7.1.7 The Chief Executive will issue a scheme of delegation for capital investment management which will be in accordance with:
- (a) SCIM guidance
 - (b) Forth Valley NHS Board Standing Orders
 - (c) the schedule of financial limits
- 7.1.8 Competitive tendering processes as per Section 8 must be followed with the exception being when the supply is proposed under special arrangements negotiated by the Scottish Government in which event the said special arrangements must be complied with. This is applicable to processes under the auspices of Frameworks Scotland and Hub Company where the formal tendering process has been deemed to have been completed in arriving at the principal supply chain partners.
- 7.1.9 The Director of Finance will issue procedures governing the financial management of capital investment projects, including variations to contract and valuation for accounting purposes.

7.2 PRIVATE FINANCE

- 7.2.1 When Forth Valley NHS Board proposes to use finance, which is to be provided other than through NHS Finances (as determined by its Capital Allocation), the following procedures shall apply:
- (a) the Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector
 - (b) where the sum involved exceeds the limits of approval delegated to the Board, a business case must be prepared, and approved by the Board
 - (c) the Business case must then be referred to the Scottish Government Health and Social Care Directorate for approval

7.3 FIXED ASSET REGISTERS

- 7.3.1 The Chief Executive who has overall control of fixed assets will delegate responsibility for ensuring the maintenance of registers of assets and for prescribing the form and content of any register and the method of updating.
- 7.3.2 The minimum data set to be held within these registers shall be as specified in the NHS Scotland Capital Accounting Manual as issued by the Scottish Government

Health and Social Care Directorate.

- 7.3.3 A fixed asset control procedure shall be approved by the Director of Finance. This procedure shall make provision for:
- (a) recording the managerial responsibility for each asset
 - (b) identification of additions and disposals
 - (c) physical security of assets
 - (d) periodic verification of the existence of condition of and title to assets
- 7.3.4 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:
- (a) properly authorised and approved agreements, architect's certificates, supplier's invoices, and other documentary evidence in respect of purchases from third parties
 - (b) stores requisitions and wages records for own materials and labour including appropriate overheads
 - (c) lease agreements in respect of assets held under a finance lease and capitalised
- 7.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
- 7.3.6 The value of each asset shall be indexed to current values in accordance with the methods specified in the NHS Scotland Capital Accounting Manual as issued by the Scottish Government Health and Social Care Directorate.
- 7.3.7 The value of each asset shall be depreciated using methods and rates as specified in the NHS Scotland Capital Accounting Manual as issued by the Scottish Government Health and Social Care Directorate.
- 7.3.8 The value of each asset shall be indexed to current values in accordance with the methods specified in the Capital Accounting Manual by the Scottish Government Health and Social Care Directorate.
- 7.3.9 Registers shall also be maintained by responsible nominated officers and receipts retained for:
- (a) equipment on loan; and
 - (b) all contents of furnished lettings.
- 7.3.10 On the closure of any facility, a check shall be carried out and a responsible officer

will certify an inventory of items held pending eventual disposal.

- 7.3.11 The Director of Finance shall approve a procedure for the calculation and payment of capital charges as specified in the NHS Scotland Capital Accounting Manual issued by the Scottish Government Health and Social Care Directorate.

7.4 SECURITY OF ASSETS

- 7.4.1 The Chief Executive is responsible for the overall control of the fixed assets of Forth Valley NHS Board, but all staff have a responsibility for the security of property of the Board. It shall be the responsibility of senior staff in all disciplines to apply appropriate routine security practices in relation to NHS property. Persistent breach of agreed security practices should be reported to the Chief Executive.
- 7.4.2 Wherever practicable, items of equipment shall be indelibly marked as Forth Valley NHS Board property.
- 7.4.3 The Director of Finance shall prepare procedural instructions on the security and checking and disposal of assets (including cash, cheques, and negotiable instruments, and also including donated assets). This procedure shall make provision for:
- (a) recording managerial responsibility for each asset
 - (b) identification of additions and disposals
 - (c) identification of all repairs and maintenance expenses
 - (d) physical security of assets
 - (e) periodic verification of the existence of condition of, and title to, assets recorded
 - (f) identification and reporting of all costs associated with the retention of an asset
 - (g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments (see Section 8)
- 7.4.4 Any damage to Forth Valley NHS Board premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors, heads of department or employees in accordance with the procedure for reporting losses.

SECTION 8 PURCHASING OF SUPPLIES AND SERVICES

8.1 DELEGATION OF AUTHORITY

- 8.1.1 The Forth Valley NHS Board will approve the total level of non-pay expenditure on an annual basis and the Director of Finance will determine the level of delegation to budget holders.
- 8.1.2 The Director of Finance will set out:
- (a) the list of managers who are authorised to approve requisitions for the supply of goods and services
 - (b) the maximum level of each requisition and the process for authorisation above that level
 - (c) the procedures to be adopted for the seeking of professional advice regarding the supply of goods and services
- 8.1.3 All non-pay expenditure will be incurred within the limits of the non-pay budgets delegated to budget holders.
- 8.1.4 Section 21 sets out Standards of Business Conduct, which must be adhered to by members and officers of Forth Valley NHS Board.

8.2 SYSTEMS AND PROCEDURES FOR REQUISITIONING, ORDERING AND RECEIVING GOODS AND SERVICES

- 8.2.1 Supplies and services must be purchased through national contracts including framework agreements in accordance with CEL 05 (2012) where these are available. Only in exceptional circumstances and only with the authority of the Head of Procurement and the Director of Finance shall supplies and services available on contract be ordered outwith national contracts.

All formal contract arrangements must include Information Governance requirements including appropriate patient confidentiality, information security, data protection and Freedom of Information requirements. The Head of Information Governance should be contacted for clarification in terms of use of standard wording and to resolve any queries that arise. The Caldicott Guardian has overall responsibility for Patient Information security.

Standard wording for inclusion within contracts has been prepared and the Head of Procurement should be contacted to confirm / advise on standard clauses. The Head of Procurement is responsible for compliance with this component of SFIs and ensuring compliance with CEL 05 (2012).

8.2.2 In line with the Procurement Reform (Scotland) Bill competitive tenders for the supply of all goods and services not available to the Board through national or regional contracts will be invited by advertising on the Public Contracts Scotland website unless:

(a) the estimated value of the contract is (exclusive of VAT):-

- less than £50,000 for building and engineering works
- less than £50,000 for other supplies
- less than £1,000 for disposals

(b) the supply or disposal is for goods or services of a special nature or character in respect of which it is not possible or desirable to obtain competitive tenders

(c) in cases of emergency where it is not practicable or where the delay would result in further expense to the NHS Board. Such cases must be reported immediately to the Chief Executive

8.2.3 Written quotations shall be obtained from firms on approved lists (where possible) where the expenditure will be more than £5,000 but less than £50,000.

8.2.4 Where competitive tenders have been obtained, the lowest shall normally be accepted or, for disposals, the highest. If other than the lowest (highest for disposals) is being recommended, the approval of the Chief Executive or the Director of Finance shall be obtained before acceptance and the reasons entered in the Register of Tenders.

8.2.5 Any Board Member or Officer concerned with a contract who has a pecuniary interest in that contract shall declare his interest in writing to the Chief Executive who shall maintain a register of all such declarations. The NHS Board Member or Officer concerned must withdraw from the decision making process of the purchasing/contracting arrangements concerning that item. (See Section 20 – Standards of Business Conduct).

8.2.6 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for Forth Valley NHS Board. In so doing, the advice of Forth Valley NHS Board sourcing adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted before any order is placed.

8.2.7 The Director of Finance shall:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once

approved, the thresholds must be incorporated in Forth Valley NHS Board Standing Financial Instructions and regularly reviewed; and

- (b) prepare procedural instructions on the obtaining of goods, services and works, incorporating the thresholds set by the Board.

8.2.8 No order may be placed for any item or items for which there is no budget provision unless authorisation is provided by the Director of Finance on behalf of the Chief Executive.

8.2.9 All goods, services, or works must be ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash. Suppliers/Contractors shall be notified that they should not accept orders unless on an official form.

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

- (a) all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made
- (b) contracts above specified thresholds are advertised and awarded in accordance with EC and GATT rules and comply with other such legislation on public procurement
- (c) where consultancy advice is being obtained, the procurement of such skills must be in accordance with guidance issued by the Scottish Government Health and Social Care Directorate
- (d) in accordance with Section 21 – Standards of Business Conduct, no order is issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than:
 - isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars
 - conventional hospitality, such as lunches in the course of working visits
- (e) verbal orders are only issued in exceptional circumstances, in cases of emergency or urgent necessity, and only by an officer designated by the Chief Executive; these must be confirmed by an official order no later than the next working day, and clearly marked “Confirmation Order”
- (f) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds

- (g) goods are not taken on trial or loan in circumstances that could commit Forth Valley NHS Board to a future uncompetitive purchase
- (h) changes to the list of directors/employees authorised to certify invoices are notified to the Head of Financial Services
- (i) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance
- (j) petty cash records are maintained in a form as determined by the Director of Finance

8.2.11 All tenders shall be addressed to the Chief Executive.

8.2.12 Official orders must:

- (a) be consecutively numbered
- (b) be in a form approved by the Director of Finance
- (c) include such information concerning prices or costs as may be appropriate
- (d) incorporate an obligation on the contractor to comply with the conditions printed thereon as regards delivery, carriage, documentation, variations, etc.

8.2.13 The Chief Executive must ensure that Forth Valley NHS Board Standing Orders are compatible with the requirements issued by the Scottish Government Health and Social Care Directorate in respect of building and engineering contracts (PROCEDURE) and land and property transactions (ESTATECODE). The technical audit of these contracts shall be the responsibility of the relevant Director. The Director of Finance shall ensure that the arrangements for financial control and audit of building and engineering contracts and property transactions comply with the guidance contained within these codes.

8.2.14 In accordance with Scottish Procurement Policy Note SPPN 2/2010 any contractor or sub-contractor performing security industry services will be required to be registered with the SIA Approved Contractors Scheme for the category of security service being provided/performed under the contract.

SECTION 9 INCOME, FEES AND CHARGES, SECURITY OF CASH AND OTHER NEGOTIABLE INSTRUMENTS

9.1 INCOME SYSTEMS

- 9.1.1 The Director of Finance shall be responsible for designing and maintaining systems for the proper recording and collection of all monies due, including income due under service agreements for the provision of patient care services. The Director of Finance shall be responsible for establishing reliable systems for financial coding to properly record all transactions.

9.2 FEES AND CHARGES

- 9.2.1 Forth Valley NHS Board shall follow the guidance and advice of the Scottish Government Health and Social Care Directorate in setting prices for Service Agreements.
- 9.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of fees and charges other than those determined by the Scottish Government Health and Social Care Directorate or by Statute.
- 9.2.3 All officers shall inform the Accounting Services Manager of money due to Forth Valley NHS Board arising from transactions which they initiate, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.3 DEBT RECOVERY

- 9.3.1 The Director of Finance is responsible for taking appropriate recovery action on all outstanding debts.
- 9.3.2 Income not received should be dealt with in accordance with losses procedures.
- 9.3.3 All staff dealing with income transactions are responsible for ensuring that underpayments against sums due are prevented, but where these occur recovery action, as determined by the Director of Finance, should be initiated.
- 9.3.4 The Director of Finance shall establish procedures for the write-off of debts after all reasonable steps have been taken to secure payment.

9.4 SECURITY

- 9.4.1 All receipt books, tickets, agreement forms or other means of officially acknowledging or recording amounts received or receivable shall be in a form approved by the Director of Finance. Such stationery shall be ordered and controlled by him and subject to the same precautions as are applied to cash.

- 9.4.2 All officers whose duty it is to collect or hold cash shall be provided with a safe or with a lockable cash box, which will normally be deposited in a safe. The officer concerned shall hold only one key and all duplicates shall be lodged with the Board's bankers or other officer authorised by the Director of Finance, and suitable receipts obtained. The loss of any key shall be reported immediately to the Director of Finance. The Director of Finance, on receipt of a satisfactory explanation, shall authorise the release of the duplicate key. The Director of Finance shall arrange for all new safe keys to be dispatched directly to him from the manufacturers. The Director of Finance shall be responsible for maintaining a register of authorised holders of safe keys.
- 9.4.3 All cash, cheques, postal orders and other forms of payment received by an officer other than the cashier shall be entered immediately in an approved form of register. All cheques and postal orders shall be crossed immediately 'Not negotiable - A/C Forth Valley NHS Board'. The remittances shall be passed to the cashier from whom a signature shall be obtained.
- 9.4.4 The opening of coin operated machines (including telephones) and the counting and recording of takings shall be undertaken by two officers together, at frequent intervals, and the coin box keys shall be held by a nominated officer. A reconciliation of monies collected should be carried out where appropriate.
- 9.4.5 The Director of Finance shall prescribe the system for the transporting of cash and un-crossed pre-signed cheques and shall approve, where appropriate, the use of the services of a specialist security firm.
- 9.4.6 Official money shall not, under any circumstances, be used for the encashment of private cheques.
- 9.4.7 All cheques, postal orders, cash etc. shall be promptly banked intact in accordance with Financial Services Operating Procedure Income Collection to the credit of the main receipts account. Disbursements shall not be made from cash received except under arrangements approved by the Director of Finance.
- 9.4.8 The holders of safe keys shall not accept unofficial funds for depositing in their safes.
- 9.4.9 During the absence (e.g., on holiday) of the holder of a safe key or cash box key, the officer who acts his place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.
- 9.4.10 All cheques shall be in a form approved by the Director of Finance. All unused cheques and other orders shall be ordered and controlled by him and subject to the same security precautions as are applied to cash. Bulk stocks of cheques shall normally be retained by the Board's Bankers and released by them only against a requisition signed in accordance with instructions issued by the Director of Finance.

9.4.11 The use of cheques with a pre-printed signature included shall be subject to such special security precautions as may be required from time-to-time by the Director of Finance.

9.4.12 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 11 - Condemnations, Losses and Special Payments).

9.5 OTHER

9.5.1 Staff, on appointment, shall be informed in writing by the appropriate departmental or Senior Manager, of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

9.5.2 Operating Procedure - Cash describes detailed guidance in respect of the handling of cash and cheques.

SECTION 10 TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND STAFF

10.1 REMUNERATION AND TERMS OF SERVICE

- 10.1.1 The Board shall establish a Remuneration Committee whose composition and remit will be set out in the Forth Valley NHS Board, Corporate Governance- Standing Orders.
- 10.1.2 The Remuneration Committee will operate within the Terms of Reference described in the Forth Valley NHS Board, Corporate Governance – Standing Orders.
- 10.1.3 The remuneration of the Chairman and Non-Executive Directors will be set in accordance with the instructions issued by the Scottish Ministers.
- 10.1.4 The Committee shall report in writing to the Board the bases for its recommendations. The Board shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of executive directors.

10.2 FUNDED ESTABLISHMENT

- 10.2.1 The establishment plans incorporated within the annual budget will form the funded establishment of the Forth Valley NHS Board.
- 10.2.2 The Director of Finance shall be responsible for designing a system of funded establishment control. The funded establishment of any department may only be varied in accordance with the approved establishment control system.

10.3 STAFF APPOINTMENTS

- 10.3.1 No director or officer may engage, re-engage or re-grade staff, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration unless
- (a) so authorised by the Chief Executive; and
 - (b) within the limit of the approved budget and funded establishment.
- 10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service, etc., for employees.
- 10.3.3 A certified appointment form and such other documents as may be required shall be sent to the Payroll Services Manager immediately upon the employee commencing duty.

10.4 CONTRACT OF EMPLOYMENT

10.4.1 Each employee shall be issued with a Contract of Employment by the Director of Human Resources, which shall comply with current employment legislation and be in a form approved by the Board.

10.4.2 The Director of Human Resources shall be responsible for dealing with variations to, or termination of, contracts of employment.

10.5 STAFF CHANGES

10.5.1 A variation to contract of employment shall be issued in all cases of changes to existing contract.

10.5.2 Confirmation of a change in the status of employment shall be completed and submitted electronically to the Payroll Services Manager.

10.5.3 A termination of employment form and such other documents as he/she may require shall be completed and submitted electronically to the Payroll Services Manager immediately upon the effective date of an employee's resignation, retirement or termination being known. Where an employee fails to report for duty in circumstances which suggest he has left without notice, the Director of Human Resources shall be informed and Payroll Services Manager thereafter.

10.6 PAYROLL

10.6.1 All pay records, related electronic records and their notification shall be in a form approved by the Director of Finance and shall be certified and submitted in accordance with their instructions.

10.6.2 The Director of Finance shall be responsible for the final determination of any pay including the verification that the rate of pay and relevant conditions of service are in accordance with current agreements, the proper compilation of the payroll and for payments made.

10.6.3 The Director of Finance shall determine the dates on which the payment of salaries and wages are to be made, having regard to the general rule that it is undesirable to make payments in advance.

10.6.4 All employees shall be paid monthly (by bank electronic transfer) (BACS) unless otherwise agreed by the Director of Finance.

10.6.5 It is the duty of each member of staff to report, immediately in the first instance, to the Payroll Services Manager, any irregular payment which has been made from funds for payroll purposes.

10.7 TRAVEL AND OTHER STAFF EXPENSES

- 10.7.1 All claims for payment of car allowances, subsistence, removal, and disturbance allowances, travelling and incidental expenses shall be submitted in a form approved by the Director of Finance.
- 10.7.2 The Director of Finance shall reimburse all expenses claimed by employees of the Board or outside parties in line with the relevant Whitley Council regulations. Arrangements for the certification of such claims by the appropriate Head of Department shall be subject to the approval of the Director of Finance
- 10.7.3 The Director of Finance shall ensure that Inland Revenue regulations with regard to travel and other staff expenses are complied with.

SECTION 11 PAYMENTS FOR ACCOUNTS AND CLAIMS

11.1 RESPONSIBILITIES FOR NOTIFYING AND MAKING PAYMENTS

- 11.1.1 All employees must comply with the approved scheme of delegation contained in the Board's Standing Orders when initiating all non-pay transactions.
- 11.1.2 The Director of Finance shall be responsible for the prompt payment of all properly authorised accounts and claims. Payment of contract invoices shall be undertaken promptly in accordance with contract terms, or otherwise, in accordance with national guidance.
- 11.1.3 All Directors, officers and agents shall inform the Director of Finance promptly of all monies payable by Forth Valley NHS Board arising from transactions which they initiate, including contracts, leases, tenancy agreements and other transactions.
- 11.1.4 Family Health Service Payments and Administration has been delegated to NSS under a Partnership Agreement. NSS will act as agents of the Board in accordance with the Partnership Agreement.

11.2 SYSTEMS AND PROCEDURES FOR MAKING PAYMENTS

- 11.2.1 The Director of Finance shall be responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by Forth Valley NHS Board. The system shall provide for:
- (a) a list of officers authorised to certify invoices, together with specimens of their signatures
 - (b) certification that:
 - where contracts are based on measurement of time, materials, or expenses, that each are in accordance with the appropriate independent certified measures
 - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained
 - the account is arithmetically correct
 - the account is in order for payment
 - (c) a timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts where cash discounts can be obtained or for those accounts which otherwise require early payment

- (d) instructions to employees regarding the handling and payment of accounts within Financial Services;
- (e) a process which ensures that payment for goods and services is only made once the goods and services have been received by Forth Valley NHS Board (except as allowed for below)

11.2.2 In the case of contracts for building or engineering works, which require payment to be made on account during progress of the works, the Director of Finance shall make payment on receipt of a certificate from the appropriate technical consultant. Without prejudice to the responsibility of any consultant or works officer appointed to a particular building or engineering contract, a contractor's account shall be subject to such financial examination by the Director of Finance and such general examination by a works officer as may be considered necessary, before the person responsible to Forth Valley NHS Board for the contract, issues the final certificate.

11.2.3 Where a contract is based on the measurement of time, materials or expenses, the checks to be carried out must provide confirmation that:

- (a) the time charged is in accordance with the time sheets
- (b) the rates of labour are in accordance with the appropriate rates
- (c) the materials have been checked as regards quantity, quality, and price
- (d) the charges for the use of vehicles, plant and machinery have been examined

11.2.4 Where an officer certifying accounts or claims relies upon other officers to do preliminary checking, he shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

11.3 OTHER

11.3.1 All employees must comply with the terms of NHS Circular MEL (1994) 48 which specifies Standards of Business Conduct for NHS Staff. Any query on the application of the standards must be raised with the Director of Human Resources.

SECTION 12 CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

12.1 FRAUD POLICY AND RESPONSE PLAN

12.1.1 The Director of Finance shall prepare a Fraud Policy and Response Plan, which shall be approved by the Board.

12.2 DISPOSALS AND CONDEMNATIONS

12.2.1 The Director of Finance shall prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

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

12.2.3 All unserviceable articles shall be:

- (a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;
- (b) 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.

12.2.4 The condemning officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report such evidence to the Director of Finance who will take the appropriate action.

12.3 LOSSES AND SPECIAL PAYMENTS

12.3.1 The Director of Finance shall prepare procedural instructions on the recording of and accounting for losses and special payments.

12.3.2 Any officer discovering or suspecting a loss of any kind shall forthwith inform his Head of Department, who shall immediately inform the Chief Executive and Director of Finance.

12.3.3 Where a criminal offence is suspected, the Board's Fraud Policy and Response Plan will be implemented.

12.3.4 The Director of Finance shall notify the Scottish Government Health and Social Care Directorate of all frauds in accordance with Board Manual of Accounts (SFR 18).

12.3.5 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance shall immediately notify:

(a) the Forth Valley NHS Board

(b) the Statutory Auditor

12.3.6 For all Family Health Service reported instances of fraud and other cases as may be determined by Scottish Government Health and Social Care Directorate, the Board will refer these matters to the NHS in Scotland Counter Fraud Service in accordance with guidance received from Scottish Government Health and Social Care Directorate.

12.4 WRITING OFF OF LOSSES

12.4.1 The Director of Finance shall maintain a losses and compensation register in which details of all losses shall be recorded, as they are known. Write-off action shall be recorded against each entry in the register.

12.4.2 The Chief Executive and Director of Finance acting jointly will approve the writing off of losses within the delegated limits to the Board. The Director of Finance will make recommendations to the Board for the writing off of losses and compensation, which exceed the delegated limits of Forth Valley NHS Board.

12.4.3 The Director of Finance shall be authorised to take any necessary steps to safeguard Forth Valley NHS Board interest in bankruptcies and company liquidations.

12.4.4 No special payments exceeding the delegated limits determined by the Board shall be made without the prior approval of the Director of Finance.

12.4.5 Losses are classified in accordance with SFR 18.1 "Details of Losses and Special Payments" issued by the Scottish Government Health and Social Care Directorate in the NHS Boards Accounts Manual for Accounts.

12.4.6 In accordance with the Scheme of Delegation, the Chief Executive may, acting together with the Director of Finance, approve the writing off of losses within the limits delegated to the Board by the Scottish Government Health and Social Care Directorate.

12.4.7 The delegated limits of authority for each type of loss are contained in the Scheme of Delegation shown in the Forth Valley NHS Board Corporate Governance: Standing Orders (June 2012)

SECTION 13 ENDOWMENTS AND TRUST FUNDS (NON-EXCHEQUER FUNDS)

13.1 INTRODUCTION

- 13.1.1 Endowment and Trust Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the National Health Service, the objects of which are for the benefit of the National Health Service in Scotland. They are administered by the Board acting as trustees or by Special Trustees appointed by the Scottish Ministers or by other persons under a trust. An Endowments Committee will be responsible for the management of Forth Valley NHS Board Endowment and Trust Funds.
- 13.1.2 The discharge of the Board's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety.
- 13.1.3 These Standing Financial Instructions shall apply equally to Non-Exchequer Funds as to other funds except that expenditure from Non-Exchequer Funds shall be restricted to the purpose(s) of the appropriate Fund.
- 13.1.4 The Director of Finance shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of Forth Valley NHS Board as trustees of non-exchequer funds, including an Investments Register.
- 13.1.5 All share and stock certificates and property deeds shall be deposited either with Forth Valley NHS Board Bankers or Investment Advisers, or in a safe, or a compartment within a safe, to which only a designated responsible officer will have access.
- 13.1.6 The Director of Finance shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for endowment funds.
- 13.1.7 The Director of Finance shall be required to advise the Board on the financial implications of any proposal for fund raising activities, which Forth Valley NHS Board may initiate, sponsor or approve.
- 13.1.8 The Director of Finance shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. After the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of Forth Valley NHS Board by the Director of Finance who alone shall be empowered to give an executor a good discharge.
- 13.1.9 Endowment and Trust Funds shall be invested by the Director of Finance in accordance with Forth Valley NHS Board policy and subject to statutory requirements. The Director of Finance shall have authority to obtain professional advice on investments.

13.1.10 Where it becomes necessary for Forth Valley NHS Board to obtain Grant of Probate, or to make application for grant of letters of administration, in order to obtain a legacy due to Forth Valley NHS Board under the terms of a Will, the Director of Finance shall be Forth Valley NHS Board nominee for the purpose.

SECTION 14 INFORMATION

14.1 RESPONSIBILITIES

- 14.1.1 The Chief Executive shall be responsible for ensuring the maintenance of archives for all documents required to be retained under the direction contained in CEL (31)2010 and the requirements of the Freedom of Information Act 2002 which is effective from 1st January 2005.
- 14.1.2 The documents held in archives shall be capable of retrieval by authorised persons.
- 14.1.3 Documents held shall only be destroyed at the express instigation of the Chief Executive.
- 14.1.4 The Director of Finance shall be primarily responsible for the accuracy and security of the computerised financial data of Forth Valley NHS Board.
- 14.1.5 The Director of Finance shall ensure that an updated Information Work Plan is prepared annually with associated information systems and technology plans as required by NHS Circular MEL (1994) 64.

14.2 FINANCIAL SYSTEMS MANAGEMENT

- 14.2.1 The Director of Finance shall:
 - (a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of Forth Valley NHS Board and individuals from inappropriate use or misuses of any financial and other information held on computer files, for which he is responsible after taking account of the Data Protection Act 1998, the Computer Misuse Act 1990, and the Freedom of Information Act 2002
 - (b) ensure that adequate data controls exist over data entry, processing, storage, transmission, and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system, including the use of any external agency arrangement
 - (c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance, and amendment
 - (d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out
 - (e) ensure that contingency planning is undertaken and that adequate contingency arrangements are in place

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

14.2.3 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themselves that:

- (a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy
- (b) data produced for use with financial systems is adequate, accurate, complete, timely and in a form determined by the Director of Finance, and that a management (audit) trail exists
- (c) finance staff have access to such data
- (d) such computer audit reviews as are considered necessary are being carried out

SECTION 15 INTERNAL AND EXTERNAL AUDIT

15.1 AUDIT COMMITTEE

15.1.1 In accordance with Standing Orders (and as set out in guidance issued by the Scottish Government Health and Social Care Directorate), the Board shall establish an Audit Committee which will provide an independent and objective view of when considering the following;

- (a) Internal control and corporate governance
- (b) Internal Audit including the approval of the Strategic Audit Plan
- (c) External Audit
- (d) Standing Orders and Standing Financial Instructions
- (e) Accounting Policies
- (f) Annual Accounts (including the schedule of losses and compensations)
- (g) Risk Management

15.1.2 Where the Audit Committee consider 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. Exceptionally, the matter may need to be referred to the Scottish Government Health and Social Care Directorate.

15.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided to Forth Valley Health Board and that this is reviewed regularly by the Audit Committee. The Audit Committee should be consulted on any decision to change the internal audit service provider and shall participate in the selection process for any new service provider.

15.2 DIRECTOR OF FINANCE

15.2.1 The Director of Finance shall be responsible for ensuring that internal audit is adequate for the needs of Forth Valley Health Board and meets the NHS mandatory audit standards. The Director of Finance will ensure that there are arrangements to measure, evaluate and report on the effectiveness of internal control and efficient use of resources by the establishment of an adequate internal audit function headed by a Chief Internal Auditor of sufficient status.

15.2.2 It shall be the responsibility of the Director of Finance to review, appraise, and to report to management upon the adequacy of follow-up action to Audit Reports in accordance with the policy approved by the Audit Committee, which shall be

reviewed at least biennially.

15.2.3 The Director of Finance shall ensure that an annual internal audit report is prepared by the Chief Internal Auditor and presented to the Audit Committee, in accordance with its timetable which contains:

- (a) a clear statement on the adequacy and effectiveness of internal control
- (b) details of major internal control weaknesses discovered
- (c) a summary of progress against plan in the previous year
- (d) quality measures as defined within the service specification

15.2.4 The Director of Finance shall be notified immediately whenever any matter arises which involves, or is thought to involve, irregularities involving cash, stores, other property of Forth Valley Health Board, or any suspected irregularity in the exercise of any function of a financial nature and shall inform the Chief Internal Auditor. The Director of Finance shall comply with the requirements of the Scottish Government Health and Social Care Directorate and of the Board's Fraud Policy in the resolution of these matters.

15.3 INTERNAL AUDIT

15.3.1 The Chief Internal Auditor shall be responsible directly to the Director of Finance for the provision of a professional and comprehensive Internal Audit Service to Forth Valley Health Board. In carrying out this responsibility the Chief Internal Auditor shall normally attend the meetings of the Audit Committee and will have the right of direct access to the Chief Executive, the Chairperson or other members of the Audit Committee.

15.3.2 The objectives and scope of Internal Audit are set out in the Government Internal Audit Standards (GIAS). Internal Audit will review, appraise, and report upon:

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

- fraud and other offences

- waste, extravagance, or inefficient administration
- poor value for money
- other causes.

15.3.3 The Chief Internal Auditor shall be 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 he shall have a duty to safeguard the confidentiality);
- (b) access to any land, premises, or employee of the Board
- (c) the production or identification by any employee of any Board cash, stores, or other property under the employee's control
- (d) explanations concerning any matter under investigation or review

15.3.4 Where a matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property of the Board, or any suspected irregularity in the function of a pecuniary nature, officers shall act in accordance with the provisions of Section 11, the Board's Fraud Policy and the requirements of the Scottish Government Health and Social Care Directorate.

15.3.5 The Chief Internal Auditor shall report in accordance with the reporting protocol approved by the Audit Committee which shall be reviewed at least biennially.

15.3.6 Counter Fraud Service (CFS) staff acting on the Director of Finance's behalf may require and receive access to:

- All records, documents and correspondence relating to transactions relevant to an investigation
- At all reasonable times to any premises or land of NHS Forth Valley

15.4 EXTERNAL AUDIT

15.4.1 The External Auditors for Forth Valley Health Board are appointed by the Auditor General for Scotland.

15.4.2 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.

15.4.3 The appointed External Auditor has a general duty to satisfy himself that:

- (a) The Board's accounts have been properly prepared in accordance with the directions given under the Public Finance and Accountability (Scotland) Act 2000
- (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

15.4.4 Additionally, Audit Scotland's Code of Audit Practice which covers the conduct of the audit, requires the appointed External Auditor to consider whether the statement of accounts represents a true and fair view of the financial position of the Board.

15.4.5 The External Auditor is required to provide an Audit Certificate and opinion to Forth Valley Health Board, Scottish Ministers and Audit Scotland. He is also required to submit a final report to members of Forth Valley Health Board, which summarises significant matters arising during the statutory audit. The auditor will also normally issue management letters to the Chief Executive and the Director of Finance highlighting any significant matters during the course of the audit.

15.4.6 The appointed External Auditor has special duties to report directly to the Auditor General should he have reason to believe that a Board decision would involve unlawful expenditure or would be unlawful and cause a loss or deficiency.

SECTION 16 ANNUAL ACCOUNTS AND REPORTS

16.1 GENERAL

- 16.1.1 Forth Valley NHS Board is required under the terms of Section 86(3) of the National Health Service (Scotland) Act 1978 to prepare and transmit Annual Accounts to Scottish Ministers.
- 16.1.2 The Director of Finance, on behalf of the Forth Valley NHS Board, shall prepare, certify, and submit annual accounts to the Chief Executive in such a form as directed by the Scottish Ministers and in accordance with the guidance and timetable laid down by the Scottish Government Health and Social Care Directorate.
- 16.1.3 The Board's Annual Accounts must be independently audited by an auditor appointed by the Auditor General for Scotland under the terms and provisions of the Public Finance and Accountability (Scotland) Act 2000.
- 16.1.4 On receipt of the audited Annual Accounts and the associated Management Letter, the Director of Finance shall:
- (a) present the proposed management response to the Audit Committee; and
 - (b) ensure that the accounts are submitted by the 30th of June each year to the Scottish Executive to be laid before Parliament before being published.
- 16.1.5 The Director of Finance shall prepare and submit annually a financial report to the Board detailing the overall performance for the preceding financial year.
- 16.1.6 The Board shall produce an Annual Report in accordance with the Guidelines issued on 15 October 2007. The document will comply with the NHS Boards Manual for Accounts and be submitted to the Scottish Government Health and Social Care Directorate.

SECTION 17 STORES AND RECEIPT OF GOODS

17.1 GENERAL RESPONSIBILITIES

- 17.1.1 The Chief Executive shall delegate to an officer of Forth Valley NHS Board the responsibility for the overall control of stores.
- 17.1.2 The Director of Finance shall be responsible for design and implementation of the systems of control.
- 17.1.3 The day to day management of stores 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.

17.2 SECURITY ARRANGEMENTS

- 17.2.1 The responsibility for security arrangements and the custody of keys for all stores locations shall be clearly defined in writing by an officer delegated by the Chief Executive and agreed with the Director of Finance.

17.3 SYSTEMS AND STORES CONTROL

- 17.3.1 All stores' records shall be in such form and shall comply with such system of control as the Director of Finance shall approve.
- 17.3.2 The Director of Finance shall set out procedures and systems to regulate stores transactions including records for receipt of goods from store and returns to store.
- 17.3.3 Wherever practicable stocks shall be marked as health service property.
- 17.3.4 Controlled stores and department stores established for immediate use should be:
- (a) maintained at the minimum practicable store levels related to operational requirements
 - (b) subject to annual stock take
 - (c) valued at the lower of cost or net realisable value
- 17.3.5 The nominated manager/pharmaceutical officer shall be responsible for a system, approved by the Director of Finance, for a review of slow moving and obsolete items and for the condemnation, disposal, and replacement of unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (See Section 11). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

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

17.3.7 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items of stores at least once a year. However, depending on the value and marketability of some items, a system of perpetual inventory checking may be applied.

17.3.8 Those stores designated by the Director of Finance as comprising more than 7 days of normal use should be:

- (a) subjected to annual or continuous stock-take
- (b) valued at the lower of cost and net realisable value

SECTION 18 PATIENTS' PROPERTY

18.1 GENERAL

- 18.1.1 The Forth Valley NHS Board has a responsibility under the Adults With Incapacity (Scotland) Act 2000 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.
- 18.1.2 The Chief Executive shall be responsible for informing patients or their guardians, as appropriate, before or at admission that the Board will not accept responsibility or liability for patient's property brought into health service premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.
- 18.1.3 The Director of Finance shall provide detailed written instructions for the receipt, custody, recording, safekeeping, and disposal of patient's property (including instructions on the disposal of the property of deceased patients and patients transferred to other premises) for all staff who have responsibility for the property of patients. The Director of Finance will also have procedures in place to deal with the loss of patients' property.
- 18.1.4 Where Scottish Government Health and Social Care Directorate instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.
- 18.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965). The production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.
- 18.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.
- 18.1.7 Where patients' property or income is received for specific purposes and held for safekeeping, the property of income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.
- 18.1.8 The Director of Finance shall prepare an abstract of receipts and payments of patients' private funds in the form laid down in the Board Manual for Accounts. This abstract shall be audited independently and presented to the Audit Committee annually, with the auditor in attendance at the meeting.

SECTION 19 RISK MANAGEMENT

19.1 GENERAL

19.1.1 The Chief Executive shall ensure that Forth Valley NHS Board has a programme of risk management, which will be approved and monitored by the Forth Valley NHS Board.

19.1.2 The programme of risk management shall include, inter alia:

- a) a process for identifying and quantifying risks and potential liabilities and addressing CNORIS
- b) engendering among all levels of staff a positive attitude towards the control of risk
- c) management processes to ensure that all significant risks and potential liabilities are addressed, including effective systems of internal control and decisions on the acceptable level of retained risk
- d) contingency plans to offset the impact of adverse events
- e) audit arrangements including external and internal audit, clinical audit, health, and safety review
- f) arrangements to review the risk management programme
- g) development of a financial risk management strategy to cope with possible in-year variations to the initially set budget

19.1.3 The existence, integration and evaluation of the above elements will provide a basis for the Audit Committee to make a statement on the effectiveness of internal control and corporate governance to Forth Valley NHS Board.

SECTION 20 PRIMARY CARE CONTRACTORS

20.1 GENERAL

20.1.1 In line with Scottish Executive arrangements, the Practitioner Services Division (PSD) of the National Services Scotland (NSS) is the payment agency for all Family Health Service (FHS) contractor payments:

- (a) General Practitioners
- (b) Dentists
- (c) Community Pharmacists
- (d) Optometrists

20.1.2 The Director of Finance shall conclude a “Partnership Agreement” with the PSD covering validation, payment, monitoring and reporting and the provision of an audit service by the NSS service auditors. The agreement will be signed off by the Chief Executive of NHS Forth Valley.

20.1.3 The relevant Committee will approve additions to, and deletions from, approved lists of contractors, taking into account the health needs of the local population, and the access to existing services. All applications and resignations received will be dealt with equitably, within any time limits laid down in the contractors’ NHS terms and conditions of service.

20.1.4 The Director of Finance will:

- (a) ensure that lists of all contractors are maintained and kept up to date; and
- (b) ensure that systems are in place to deal with applications, resignations, inspection of premises, etc., within the appropriate contractor’s terms and conditions of service.

20.1.5 The Director of Finance shall ensure that NSS systems are in place to provide assurance that:

- (a) only contractors who are included on the Board’s approved lists receive payments;
- (b) all valid contractors’ claims are paid correctly, and are supported by the appropriate documentation and authorisations
- (c) all payments to third parties are notified to the General Practice Independent Contractors on whose behalf payments are made

(d) ensure that regular independent post payment verification of claims is undertaken to confirm that:

- rules have been correctly and consistently applied
- overpayments are prevented wherever possible; if, however, overpayments are detected, recovery measures are initiated
- fraud is detected and instances of actual and potential fraud are followed up

(e) exceptionally high/low payments are brought to his/her attention

(f) payments made via the NSS are reported to NHS Forth Valley

(g) payments made on behalf of the Board by the NSS are pre-authorised

(h) payments made by the NSS are reconciled with the cash draw-down reported by the Scottish Executive to Health Boards

20.1.6 The Director of Finance shall prepare operating procedures to cover all payments made by the NSS (both payments made directly or payments made on behalf of the Board).

20.1.7 Payments made to all Primary Care independent contractors and community pharmacists shall comply with their appropriate contractor regulations.

SECTION 21 STANDARDS OF BUSINESS CONDUCT

Detailed information is available in the NHS Forth Valley Policy on Standards of Business Conduct.

MEL (1994) 80 also provides details of the principles for standards of conduct and accountability in situations when there is potential conflict between the private interests of NHS staff and their duties.

21.1 GENERAL RESPONSIBILITY

21.1.1 It will be the responsibility of the Chief Executive to:

- (a) ensure that Scottish Government Health and Social Care Directorate guidelines on standards of business conduct for NHS staff (MEL (1994) 48) are brought to the attention of all staff, and are effectively implemented
- (b) develop local conflict of interest policies and the machinery to implement them, in consultation with staff and local staff representatives
- (c) ensure that such policies and procedures are kept up to date
- (d) ensure that a full operational policy on the Standards of Business Conduct is developed and communicated to staff

21.1.2 The business of the Board will be conducted in accordance with the Ethical Standards in Public Life etc (Scotland) Act 2002. All members of staff have a duty to maintain strict ethical standards in the conduct of their business as an employee of Forth Valley NHS Board.

21.1.3 It is the responsibility of all staff when acting on NHS Forth Valley's behalf to:

- conduct the business of the organisation professionally, with honesty, integrity, free from bribery and maintain the organisations reputation
- if staff are in any doubt as to what they can or cannot do they must seek advice from their line manager or from the Corporate Services Department

Breaches may lead to disciplinary action or to dismissal.

21.1.4 BRIBERY ACT 2010

The Bribery Act 2010 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 Forth Valley to give, promise or offer a bribe or to request, agree to receive or accept a bribe (section 1,2 and 6 offences). This can be punishable for an individual by imprisonment of up to 10 years.

In addition, the Act introduces a corporate offence (section 7 offence) which means that NHS Forth Valley can be exposed to criminal liability, punishable by an unlimited fine 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 standalone offence and would follow a bribery/corruption offence committed by an individual associated with NHS Forth Valley in the course of their work.

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 Forth Valley, under the Act the Director or Senior Officer would be guilty of an offence (Section 14 offences) as well as the body corporate which paid the bribe.

Whilst the exact definition of bribery and corruption is a statutory matter the following working definitions are given

- Bribery is an inducement or reward offered, promised, or provided in order to gain any commercial, contractual, regulatory, or personal advantage.
- Broadly, the Act defines bribery as giving or receiving a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith.
- Bribery does not have to involve cash, or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event.
- Corruption relates to a lack of integrity or honesty including the use of trust for dishonest gain. It can broadly be 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.

21.2 GIFTS, HOSPITALITY AND INDUCEMENTS

21.2.1 The policy on the Standards of Business Conduct applies to all members of staff at all times.

21.2.2 Officers of Forth Valley NHS Board should not accept business gifts, but articles of a low intrinsic value such as chocolates, biscuits, business diaries or calendars, need not necessarily be refused. No gifts of alcohol should be accepted.

21.2.3 Care should be taken when accepting hospitality. All hospitality offered, such as

lunches and dinners, corporate hospitality events, etc should be reported to the officer's superior before acceptance.

21.2.4 Any inducements offered should be reported to the officer's superior.

21.2.5 Visits at suppliers' expense to inspect equipment etc should not be undertaken without the prior approval of the Chief Executive and in the case of the Chief Executive by the prior approval of the Chairperson.

21.2.6 A register to record gifts reported by staff will be maintained and it is the responsibility of the recipients of such gifts to report all such items received to the Corporate Services Department for recording. The form 'Declaration of Staff interests and Gifts/Hospitality' (Annex 2 of the Policy on Standards of Business Conduct' should be used for this purpose. This register will be published on the NHS Forth Valley website.

21.3 ACQUISITION OF GOODS AND SERVICES

21.3.1 If officers are involved in the acquisition of goods and services, they should adhere to the ethical code of the Institute of Purchasing and Supply.

21.3.2 Officers should ensure that acceptance of commercial sponsorship will not influence or jeopardise purchasing decisions.

21.4 DECLARATION OF INTERESTS

21.4.1 To avoid conflicts of interest and to maintain openness and accountability all directors, members of staff and non-executive board members have a responsibility to promptly declare relevant interests and any changes to those interests that may arise from time to time.

Employees are required to register all interests that may have any relevance to their duties / responsibilities. These include any financial interest in a business or any other activity or pursuit that may compete for an NHS contract to supply either goods or services to the NHS or in any other way that could be perceived to conflict with the interests of NHS Forth Valley. The test to be applied when considering appropriateness of registration of an interest is to ask whether a member of the public acting reasonably might consider the interest could potentially affect the individual's responsibilities to the organisation and/or influence their actions. If in doubt the individual should register the interest or seek further guidance from the Corporate Services Department.

Interests that it may be appropriate to register include :-

- (i) Other employment including self-employment
- (ii) Directorships including Non-Executive Directorships held in private companies or public limited companies whether remunerated or not

- (iii) Ownership of, or an interest in private companies, partnerships, businesses, or consultancies
- (iv) Shareholdings in organisations likely or possibly seeking to do business with the NHS (the value of shareholdings need not be declared)
- (v) Ownership of or an interest in land or buildings which may be significant to, of relevance to, or bear upon the work of NHS Forth Valley
- (vi) Any position of authority held in another public body, trade union, charity, or voluntary body
- (vii) Any connection with a voluntary or other body contracting for NHS services
- (viii) Any involvement in joint working arrangements with Clinical or other Suppliers

This list is not exhaustive and should not preclude the registration of other forms of interest where these may give rise to a potential conflict of interest upon the work of NHS Forth Valley. Any interests of spouses, partner or civil partner, close relative or associate or persons living with the individual as part of a family unit will also require registration if a conflict of interest exists.

21.4.2 Forth Valley NHS Board will maintain a Register of Interests and make this available for inspection by members of the public.

SECTION 22 SUSPECTED THEFT, FRAUD & OTHER FINANCIAL IRREGULARITIES

22.1 INTRODUCTION

22.1.1 The following procedures should be followed, as a minimum, in cases of suspected theft, fraud, embezzlement, corruption or other financial irregularities to comply with the Counter Fraud Service Strategy (CEL (2008) 3) and protocols. This procedure also applies to any non-public funds.

22.2 THEFT, FRAUD, EMBEZZLEMENT, CORRUPTION AND OTHER FINANCIAL IRREGULARITIES

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

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

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

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

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

22.3 REMEDIAL ACTION

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

22.4 REPORTING TO THE SCOTTISH GOVERNMENT HEALTH AND SOCIAL CARE DIRECTORATE

22.4.1 While normally there is no requirement to report individual cases to the Scottish Government Health and Social Care Directorate (SEHD) there may be occasions where the nature or scale of the alleged offence or the position of the person or persons involved, could give rise to national or local controversy and publicity. Moreover, there may be cases where the alleged fraud appears to have been of a particularly ingenious nature or where it concerns an organisation with which other health sector bodies may also have dealings. In all such cases the SEHD must be notified of the main circumstances of the case at the same time as an approach is made to the CFS.

22.4.2 The Director of Finance shall ensure submission of quarterly monitoring forms to Counter Fraud Services as set out in CEL 44 (2008).

22.5 RESPONSES TO PRESS ENQUIRIES

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

APPENDIX A TENDERING AND CONTRACT PROCEDURES

1. TENDERING PROCESS

- 1.1 The Chief Executive shall prescribe standard conditions of contract appropriate to each class of supplies and services and for the execution of all works. All contracts entered into shall incorporate the appropriate set of conditions.
- 1.2 All invitations to potential contractors to tender shall include a notice, warning tenderers of the consequences of engaging in any corrupt practices involving Board employees.
- 1.3 In the event of tenders being required notification should be sent to the Head of Corporate Services (Chief Executive's Office) indicating tender request sent out, details of the tender, closing date and time and the number of anticipated submissions.
- 1.4 A record will be maintained of all invitations to tender.
- 1.5 Tenders shall be invited in plain sealed envelopes addressed to the Chief Executive. The envelope shall be marked 'Tender for ' but shall not bear the name or identity of the sender.
- 1.6 Unopened tenders shall be date stamped and stored unopened in a secure place until after the closing date or time.
- 1.7 Tenders shall be opened as soon as possible after the stated closing date or time by the officer nominated by the Chief Executive, in the presence of an independent witness, normally from the Finance Directorate.
- 1.8 Details of each tender received should be entered into a register or record of tenders and will be signed by both officers. Tender documents shall also be date stamped and signed on the front page and all priced pages initialled by both officers.
- 1.9 Where it is in the interests of the Board, late, amended, incomplete, qualified, or not strictly competitive tenders may be considered. In such circumstances a full report shall be made to the Chief Executive who may admit such tenders. This approval must be given in writing by the Chief Executive. Where a Company invited to tender requests a delay in the submission, deferment, if approved, shall be notified to all the Companies concerned. A record of all delays requested, and the outcome of the request shall be maintained.
- 1.10 The examination of the tenders received shall include a technical assessment, and a written report on the result, containing a recommendation should be made to the Chief Executive. At the same time, staff responsible for making this recommendation shall declare in writing that they have no pecuniary interest in the

recommended Company.

- 1.11 The Chief Executive may accept the tender provided it is the lowest (or for disposals the highest) and has been recommended for acceptance, and that on the advice of the Director of Finance, financial provision is available within the overall Board resource. If it is proposed to accept a tender other than the lowest, the Chief Executive will record the reason for this decision. e.g., best overall lifetime cost.
- 1.12 All officers shall follow guidance from Scottish Government Health and Social Care Directorate.
- 1.13 Payment under the contract shall be made by the Director of Finance who shall have the right to carry out such financial examinations and checks as considered necessary before making payment.
- 1.14 Approval for increases in prices allowed under an appropriate variation of prices clause in a contract for supplies and services shall be given by the Chief Executive
- 1.15 No contract for the purchase of computer equipment or software outwith the IM&T Department shall be entered into without the Director of Finance's prior written approval.
- 1.16 Post-tender negotiation may be undertaken where it is anticipated that such action will reduce cost to the Board and where such negotiation has specially been approved in advance by the Chief Executive and Director of Finance. In such circumstances the negotiation must take place with not less than two employees of the Board present both of whom must be approved for the purpose by the Chief Executive. A record of the names of those present at the negotiation must be kept along with a record to the final prices and conditions agreed.
- 1.17 Where post-tender negotiation is undertaken with some but not all of the companies who submitted tenders a record of criteria for the selection must be kept by the managers concerned. Companies invited to post-tender negotiation must include those in the following categories:
 - (a) Companies who, following analysis of the original tender offers, are one of the cheapest three for each product item.
 - (b) The two companies "winning" the highest number total value of business following analysis of the original tender offers.
- 1.18 In addition to complying with the sections above officers involved in post-tender negotiation should familiarise themselves with the guidance produced by the Central Unit on Purchasing issued by HM Treasury.
(See: www.hm-treasury.gov.uk/pub/html/docs/cup/guidance.html)

- 1.19 For the period between opening of tenders and completion of the post-tender negotiation the tender documents shall be stored in a secure place when not actively under analysis.
- 1.20 Consultants appointed by the Board to be responsible for the supervision of a contract on its behalf shall comply with these Standing Financial Instructions as though they were officers of the Board.
- 1.21 In circumstances where the need for additional work is identified, the process is as follows
- (a) potential for additional work, if feasible, should be identified at the tender specification stage. Tenders should identify a call-off rate applicable should additional work be required.
 - (b) if additional work is identified during the process a written specification must be provided to the tenderer. A written quotation must be received. Approval to accept the written quotation must be provided by the Chief Executive or the Director of Finance together with confirmation that resources are available to meet the quotation. A monitoring report must be prepared on completion of the additional work to confirm work has been undertaken in line with the specification.
 - (c) a separate tender exercise is required if the value of additional work exceeds £20,000.

SECTION F

Risk Management

1. Introduction

The Risk Management Strategy sets out the principles and approaches to risk management which are to be followed throughout NHS Forth Valley. Its objective is to achieve a consistent and effective application of risk management and enable it to be embedded into all core processes, forming part of the day-to-day management activity of the organisation. Risk Management, when deployed effectively, should add value by supporting day-to-day activities as opposed to being seen as a separate, self-contained process and this Strategy supports this approach.

1.1 What is a Risk?

A risk can be defined as ‘the effect of uncertainty on objectives’ (*ISO31000*). It is essentially any uncertain event which can have an impact upon the achievement of an organisation’s objectives – either reducing the likelihood of achievement or stopping it altogether.

Not every perceived problem or adverse event is a risk. An important distinction must be made between what is a risk and what is an issue – or in other words, an uncertainty and a certainty. A risk is an event that may or may not happen. An issue or adverse event is something that is currently happening or has already happened. Issues and adverse events should therefore not be recorded and treated as risks.

1.2 What is Risk Management?

Risk management is a systematic way of dealing with that uncertainty which involves the identification, analysis, control and monitoring of risk. Risk Management activities are designed to achieve the best possible outcomes and reduce the uncertainty. An effective system of risk management will draw together all types of risks and enable an interrelated view of the organisation’s risk profile.

1.3 Why do we need Risk Management?

An effective system of risk management will deliver a range of outputs:

- Ensuring compliance with legislation, regulations and other mandatory obligations
- Providing assurance to internal and external governance groups that risks are being effectively controlled
- Ensuring that decision making is informed and risk-based in order to mitigate threats to the achievement of key strategic objectives
- Supporting organisational resilience
- Raising awareness of the need for everyone to adopt consistent risk management behaviours and actions in our everyday business
- Empowering all staff to make sound judgements and decisions concerning the management of risk and risk taking
- Anticipating and responding to changing political, environmental, social, technology and legislative requirements and / or opportunities
- Preventing injury and / or harm, damage and losses.

Effective risk management will be achieved by:

- Clearly defining roles, responsibilities and governance arrangements for individuals, teams and assurance committees within NHS Forth Valley

- Incorporating risk management in all System Leadership Team, Health Board, Integration Joint Board and Assurance Committee reports and when taking decisions
- Demonstrating and reinforcing the importance of effective risk management principles in our everyday activities
- Maintaining risk registers at all levels that are linked to the organisation's strategic objectives
- Monitoring and reviewing arrangements on a regular basis
- Seeking assurance that controls relied on to mitigate risks are effective

2. Risk Architecture

The arrangements for communication, governance, reporting, roles and responsibilities forms the organisation's overarching risk architecture. Defining a consistent approach to how and where risk information is communicated is essential to developing a positive risk culture and to ensuring risk management is appropriately deployed to support NHS Forth Valley.

Risks, once identified, are captured on risk registers. Each Department and Specialty will hold a risk register for its area – these form the bottom level of risk registers. Overall there are four levels of risk register and an escalation route exists for risks that cannot be fully mitigated at the Department / Speciality level. This risk register hierarchy is detailed below.

Risk Register Hierarchy



Strategic Risk Register

Risks contained in the Strategic Risk Register (previously known as the Corporate Risk Register) are the high level risks that could impact the delivery of longer term strategic objectives of the organisation. Risks are not escalated/de-escalated from lower level risk registers to the Strategic Risk Register. Instead, risk identification for the Strategic Risk Register is facilitated through twice yearly review and horizon scanning sessions led by SLT.

Organisational Risk Register

Risks contained in the Organisational Risk Register are top level, cross cutting risks that present a significant short-medium term threat to multiple Directorates. Risks are escalated and de-escalated via the Directorate Risk Register(s).

Directorate Risk Registers

Each Directorate holds a risk register that contains a cut of the most significant risks from its component Departments / Specialties. Risks are escalated to the Directorate level via the individual Department / Specialty risk registers.

Department

Each Department and Specialty will hold a risk register for its area – these form the bottom level of risk registers.

2.1 Risk Escalation

Risk escalation is a process that ensures significant risks identified that cannot be managed by a local team, department or specialty are escalated appropriately following the risk register hierarchy and line management arrangements. The following questions should be asked when deciding whether to escalate a risk:

- Does the risk present a significant threat to the achievement of Government objectives and/or standards?
- Is the risk score assessed to be intolerable or beyond the organisation's risk appetite?
- Does the risk have a widespread impact beyond a local area, e.g., does it affect multiple Departments or Directorates or does it have dependencies on multiple Departments or Directorates to mitigate?
- Does the risk present a significant cost beyond the scope of the budget holder?

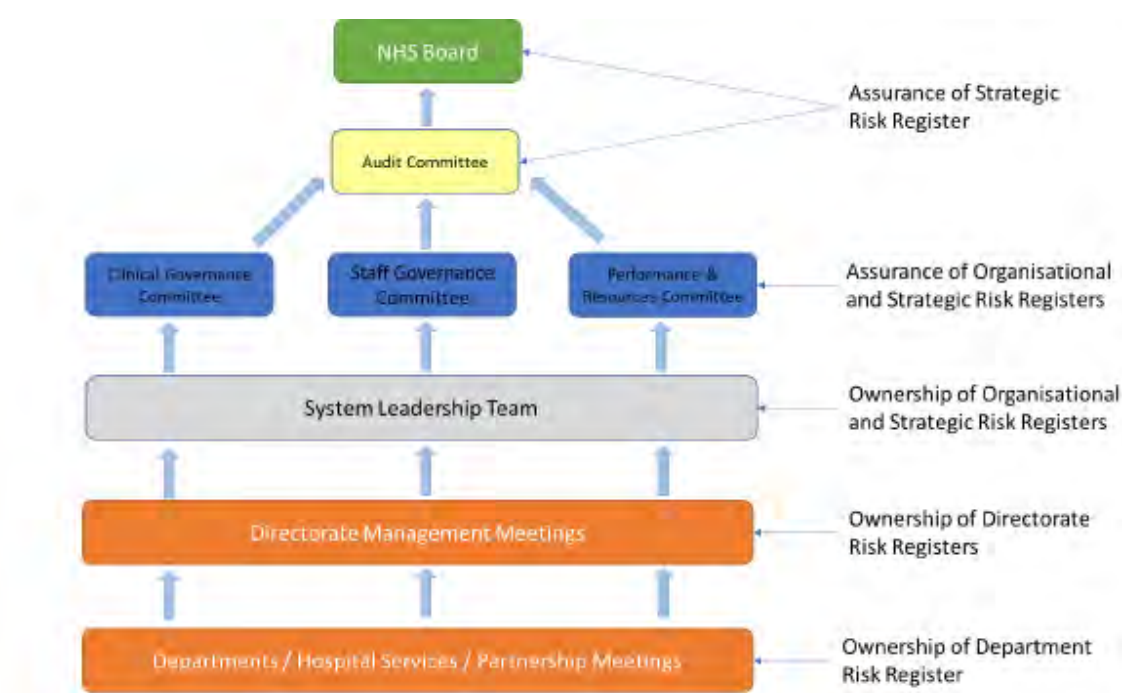
Risk score and organisational risk appetite should be key considerations when recommending risks for escalation.

2.2 Governance & Reporting

The Board of NHS Forth Valley is corporately responsible for the Risk Management Strategy and for ensuring that significant risks are adequately controlled. To support the Board a number of formal committees have been established and are responsible for various aspects of risk management, principally these are the Audit, Performance & Resources, Clinical Governance and Staff Governance Assurance Committees. All Health Board Committees are responsible for providing assurance on the effective management of risks relevant to their area of responsibility. In addition, the Audit Committee has a responsibility for overseeing the operation of the Risk Management Strategy, taking assurance from the System Leadership Team.

Diagram 1 illustrates NHS Forth Valley’s risk management governance structure.

Diagram 1: Risk Management Governance Structure



2.3 Roles & Responsibilities

Risk Management Roles & Responsibilities	
NHS Board	
<ul style="list-style-type: none"> • Provide Oversight and Scrutiny of NHS Forth Valley’s risk management arrangements to seek assurance on their effectiveness • Approve risk appetite within NHS Forth Valley 	
Chief Executive	
<ul style="list-style-type: none"> • To have overall accountability for the management of risk across NHS Forth Valley 	
System Leadership Team	
<ul style="list-style-type: none"> • Set risk appetite within NHS Forth Valley • Ensure risk management processes are supported to provide them with adequate information and assurance related to strategic and organisational risks 	
Audit Committee	
<ul style="list-style-type: none"> • To evaluate and recommend approval of the strategies and frameworks in respect of risk management to the NHS Board 	

- To approve updates and provide direction in respect of risks held within the strategic and organisational risk registers
- To review the organisation's risk culture and maturity and direct action in pursuit of continuous improvement in this area
- To formally approve the strategic risk register for onward reporting to the NHS Board

Assurance Committees

- To ensure that an appropriate approach is in place to deal with risk management across the system working within the NHS Forth Valley Risk Management Strategy

Executive and Non Executive Directors

- To ensure that risk management processes are providing appropriate information and assurances relating to risks in Directorates
- Promote the importance of risk management and foster a good risk culture within their area of responsibility
- Approve escalation of Directorate level risks where appropriate

Corporate Risk Manager

- Responsible for the implementation of the Risk Management Strategy
- Ensure risks are properly identified, understood and managed across all levels within the organisation
- Report on the organisation's risk profile at various levels to Directorates, Assurance and Audit Committees and NHS Board
- Periodically review the Risk Management Strategy and arrangements, identifying areas for potential improvement
- Drive an improving risk culture through risk education, awareness and embedding into day to day management

Risk Owner

- Accountable for ensuring the effective management of a risk

Risk Lead

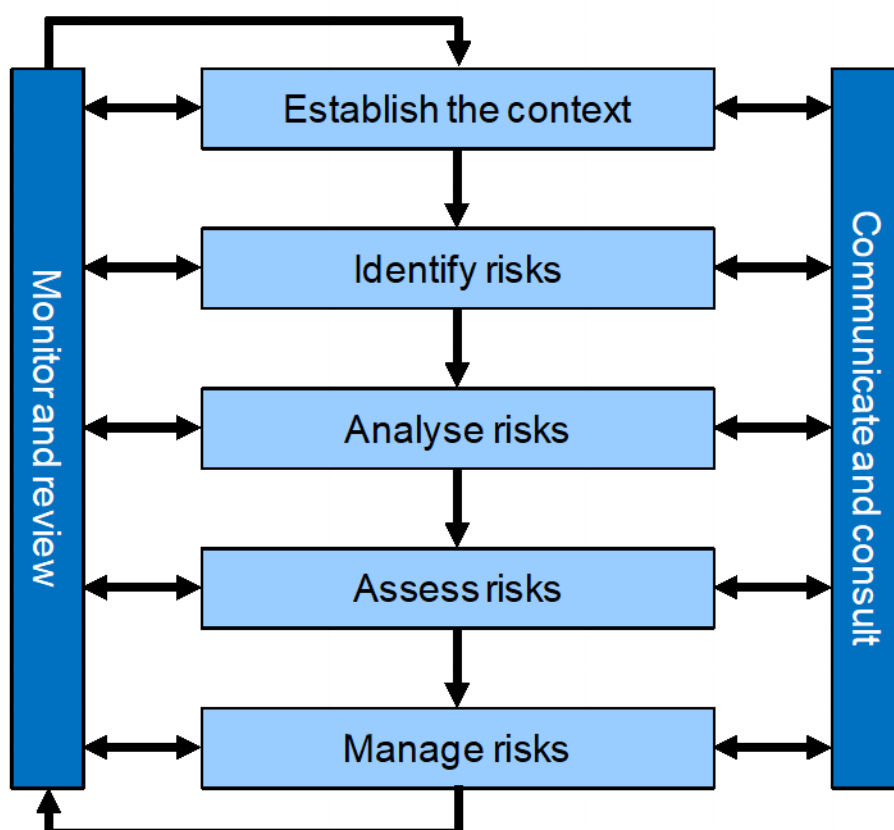
- Responsible for managing a risk on a day-to-day basis, assessing the risk score and updating the management plan, reviewing the risk on a regular basis

Risk Champion

- Responsible within an individual speciality, department or Directorate area for maintaining lines of communication with the risk function, administering the risk register and co-ordinating all risk activities

3. Approach to Risk Management

3.1 Risk Management Process – ISO31000



The above diagram demonstrates the whole process and cycle of risk management under the international standard ISO 31000.

The standard as outlined above makes clear that risk management is a dynamic process, with frequent review of existing risks and monitoring of the environment necessary to ensure the risks captured represent the current profile of the organisation.

Continual communication of risks within the organisation is essential to allow for informed decision-making. Communication to the Health Board and other stakeholders is also imperative to allow effective scrutiny and provide assurance that our risk profile is being effectively managed. It is also imperative to consult with and receive information from other departments within the organisation and our stakeholders to inform the management of our risks.

3.1.1 Step 1: Establish Context

The purpose of establishing context is to customise the risk management process, enabling effective risk analysis and appropriate risk treatment. In order to identify risks, we need to understand what we are assessing risk *against*. We must set risks within the context of the team, specialty, department and overall organisation. In addition, we need to recognise the internal and external drivers that could create risk.

Risks should be set against what we are trying to achieve as an organisation – our strategic objectives. In this stage it is important to ensure there is a common understanding of what those objectives mean at a team, specialty, department and organisational level in order that risk identification is not based on an inconsistent set of assumptions.

3.2 Step 2: Identify Risks

Once a clear, common set of objectives are agreed, the next step of the process is to identify potential risks that will prevent us from achieving them.

A range of techniques can be used for risk identification. Some prompts to consider:

- What might impact on your ability to deliver your objectives
- What does our performance data tell you?
- What do our audit and scrutiny reports tell us?
- Do you have experience in this area? Do you know or do you need to involve others?
- Should you involve partners or specialists in your risk identification?
- Lessons learned – what happened before?

Risk can be identified in a multitude of ways, through focused identification sessions or as a product of other work:

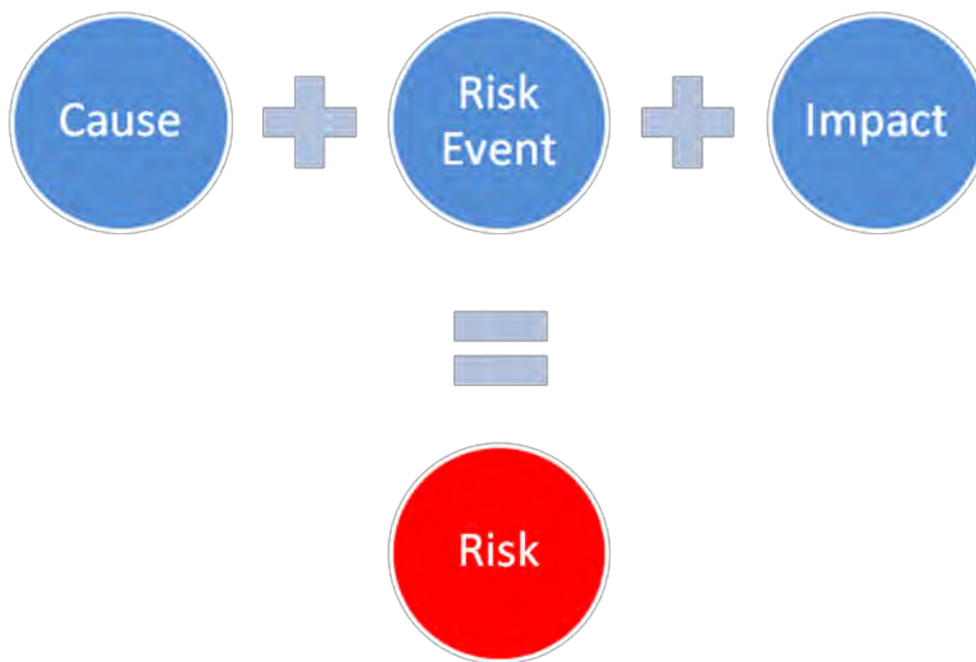
Focused Identification Methods	Other Identification Opportunities
<ul style="list-style-type: none">• Risk Identification Workshops• Risk Questionnaires• Review & refresh of existing risk registers• Interviews	<ul style="list-style-type: none">• Horizon scanning• Board meetings / working groups / management meetings• Audit & scrutiny reports• Performance data• Risk Management training

The Risk Management function facilitates risk identification workshops with Departments to direct an in-depth review of new or emerging risks.

It is important to note that just because a risk cannot be fully mitigated by the organisation alone does not mean that it should not be captured. If the risk exists to the organisation, then it should be captured, managed as far as practicable and then monitored. Ongoing management of the risk may well be in conjunction with partner agencies or influence can be exerted over those capable of mitigating the risk to within an acceptable level.

3.3 Step 3: Analyse Risks

Once a risk has been identified it must be described in a certain way in order to effectively understand, manage and mitigate it. The risk description should contain three essential components:



These three components can be included within the description as follows:

**“If [insert cause here], there is a risk that
[a certain event that may happen], resulting in
[describe impact this will have if it manifests]”**

An example of an effective risk description might be:

If there is insufficient in external funding and continued uncertainty over our cost base there is a risk that NHS FV will be unable to achieve financial sustainability, resulting in Scottish Government intervention and a detrimental impact on service delivery.

3.4 Step 4: Assess Risks

The assessment, or scoring, of risk allows for prioritisation by severity. Determining the likelihood and impact of a risk and utilising a standardised assessment criteria to assign a score based on these factors allows us to understand and prioritise which risks to mitigate first. Three scores must be assigned to cover the full trajectory and lifespan of the risk:

Untreated Score

This is the inherent risk score, that is the score with no controls applied. This score represents the “worst case scenario” for the risk. If there were no controls, mitigation, or contingency plans in place, how likely is it the risk would materialise and what would the impact be?

Current Score

Considering any controls that are currently in place to manage the risk, how does the risk score compare to the untreated score? This is the current score. Current risk score is assessed on a regular basis to establish the effectiveness of the controls applied to the risk. It is also

the current score that is the key indicator used to determine if the risk should be considered for escalation.

Target Score

The target risk score is the optimum position for the risk. Once all controls have been adequately implemented, what will the residual risk score be? Target risk scores should reflect the organisation's risk appetite and align with the amount and type of risk NHS Forth Valley is willing to accept. Risk controls should be designed to actively reduce the risk score towards the target level.

Risk Appetite

Risk appetite is the amount of risk that NHS Forth Valley is prepared to accept, tolerate, or be exposed to at any point in time. The Health Board may have different appetites for different categories of risk. As part of the Health Board's annual performance review, the Board will consider its risk appetite for each of the categories of risk as set out below:

- Hungry (eager to be innovative and to choose options offering potentially bigger rewards despite greater inherent risk)
- Open (willing to consider all options and choose the one that is most likely to result in success, while also providing an acceptable level of reward)
- Cautious (preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward)
- Minimalist (preference for ultra-safe business delivery options that have a low degree of inherent risk and only have a potential for limited reward)
- Averse (avoidance of risk and uncertainty is a key organisational objective)

The Health Board will need to consider the level and types of risk it is prepared to take in delivering its corporate objectives.

Risk Assessment Matrix

The risk assessment matrix is a 5x5 scoring mechanism which will identify a score between 1 (1x1) at the lowest and 25 (5x5) at the highest possible score.

When utilising the impact criteria on the assessment matrix, a score must be applied for every category of impact applicable to that risk. For example, one risk may have a financial impact, an impact to patient experience and reputational implications. The impact category with the highest scoring criteria will identify the overall impact score for that risk.

Assessment of likelihood is considered on a sliding scale from 1 to 5, with 1 representing 'very unlikely' and 5 'very likely.'

Once both scores have been identified, they are multiplied giving the overall *untreated, current or target* score.

The risk assessment matrix is summarised below, and a full copy included at Appendix B.

LIKELIHOOD	5	Medium 5	High 10	High 15	Very High 20	Very High 25
	4	Medium 4	Medium 8	High 12	High 16	Very High 20
	3	Low 3	Medium 6	Medium 9	High 12	High 15
	2	Low 2	Medium 4	Medium 6	Medium 8	High 10
	1	Low 1	Low 2	Low 3	Medium 4	Medium 5
		1	2	3	4	5
		IMPACT				

Categorisation

All risks, once identified, must be categorised into one of the recognised categories in order to understand the overall risk profile for the organisation. As with the overall impact score identified for a risk, the categorisation of a risk is based upon the impact score. Whichever impact category has the highest scoring criteria for that particular risk will indicate which category the risk will fall within.

For example, a risk scoring a 3 for impact in Patient Experience but scoring a 5 in Finance will categorise that risk as Finance overall. Risk categories outlined in the risk assessment matrix:

- Patient Experience
- Objectives / Project
- Injury / Illness (physical and psychological) to patient / staff / visitors
- Complaints / claims
- Service / Business interruption
- Staffing and competence
- Financial (including damage / loss / theft / fraud)
- Inspection / audit
- Adverse publicity / reputation

3.6 Step 5: Manage Risks

The purpose of this step is to select and implement the appropriate action to respond to the risk. There are four broad ways we can respond to risk, known as the 4 Ts:

- **Tolerate:** this is the decision to accept the risk at its current level. The ability to do anything may be limited, or the cost of taking action may be disproportionate to the benefit gained. This response must be viewed in the context of the organisation's risk appetite. It is not acceptable to tolerate a risk above our stated appetite.

- **Treat:** this is the decision to retain the activity or process creating the risk and to take action to implement risk controls that reduce either the likelihood of the risk occurring or minimising the impact.
- **Transfer:** this is the decision to transfer the impact of the risk either in full, or in part, to a third party. The most common form of risk transfer is insurance.
- **Terminate:** this is the decision to stop doing the activity associated with the risk. This may not always be possible and may create risks elsewhere as a result.

Risk Controls

Risk controls are management measures put in place to effectively manage a risk to within acceptable levels (i.e., within target score). It is essential that the controls put in place to manage a risk are effective. The identification of effective controls is the most important part of the whole risk management process as without this element we would simply be identifying risks and doing nothing to manage them.

To assess whether the controls we identify are or will be effective, it is important to consider the following:

- What do you already have in place to manage the cause and / or impact of the risk? E.g., policies, procedures, projects, training courses, business continuity plans etc
- Do they work? A policy which is in place but never complied with is not an effective one
- Are there any gaps in your controls?
- Do you have all the information that you need about this risk or do you need to find out more?
- What more should you do?
- If several activities are required to manage the risk, how will you prioritise these?
- Are these controls within the remit of your department? If not, you will need to liaise with stakeholders to ensure that appropriate controls are put in place.
- If you implement the controls you have identified, will this manage the risk to within acceptable levels for that risk category? If the answer is no, further controls are required.

There are two main types of control measure that can be put in place to manage a risk:

- *Preventative Controls:* These are mitigating actions which will work to control the cause of the risk and prevent it happening in the first place
- *Contingency Controls:* These are actions that can be put in place to reduce the impact of the risk if it does materialise. Contingency controls are often aligned to the business continuity plans of an organisation.

3.7 Monitor and Review

Risk Review

Once the process of identifying, analysing, and assessing a risk are complete, it is imperative that it is subject to regular review. Ongoing management and review of a risk is the most important part of the process as maintaining or reducing the risk score to within an acceptable level assures the overall management of the organisation's profile.

Required risk review timescales are outlined below:

Very High (20-25)	Monthly
High (10-16)	Monthly
Medium (4-9)	Quarterly
Low (1-3)	Quarterly

During a risk review, the risk must be re-assessed. If it is identified that the risk continues to exist, the list of current controls and further controls required must be checked, cross-referenced, and added to where necessary. On the basis of progress with controls and an assessment of the risk environment, a re-assessment of the current score must be made using the risk assessment matrix. This will show whether the risk is decreasing, increasing or remaining static. Depending on its escalation level, a change to risk score will be reported at the appropriate assurance committee.

3.8 Communicate and Consult

Communication at all levels is important to allow for informed decision making, and provision of assurance that our risk profile is effectively managed – this is achieved through risk reporting.

Risk Reporting

A quarterly risk management report is presented to the Health Board which reports on our strategic risks. In addition, Assurance Committees are provided with a regular risk management report on strategic and organisational risks assigned to their area of scrutiny. The System Leadership Team acts as the Risk Management Steering Group and provides recommendations to the Board on the escalation, de-escalation, and closure of strategic level risks. Directorates and Departments are expected to carry out regular review, monitoring and reporting on their risk registers (supported by the risk management function) in order to ensure that risks are identified and escalated to the appropriate level at an early stage.

The risk management reporting in place includes a range of risk management KPIs and trend analysis that enhances oversight and assurance for the Health Board. An annual report on risk management is also produced for the Health Board.

The Health and Social Care Integration Schemes for both Falkirk Integration Joint Board (IJB) and Clackmannanshire and Stirling IJB detail the requirements and responsibilities regarding

Risk Management for the IJBs and constituent parties. The IJBs will establish a Risk Management Strategy including a risk monitoring framework, and a Risk Register, to be maintained and shared between parties. Risks on delegated services which are shared between parties will require to be communicated across partner organisations with clear responsibilities, ownership, and timescales.

APPENDIX A: GLOSSARY

Assurance. Stakeholder confidence in our service gained from evidence showing that risk is well managed.

Contingency. An action or arrangement that can be implemented to minimise impact and ensure continuity of service when things go wrong.

Current Risk Score. The risk score identified considering any controls that are currently in place to manage the risk.

Governance. The system by which organisations are directed and controlled to achieve objectives and meet the necessary standards of accountability, probity and openness in all areas of governance.

Internal Control. Corporate governance arrangements designed to manage the risk of failure to meet objectives.

Issue. Something that has happened and is currently affecting the organisation in some way and needs to be actively dealt with and resolved.

Likelihood. Used as a general description of probability or frequency which can be expressed quantitatively or qualitatively.

Risk. An uncertain event, or set of events, which, should it occur, will have an effect on the organisation's ability to achieve its objectives.

Risk Appetite. The level of risk that an organisation is prepared to accept in pursuit of its objectives.

Risk Architecture. All of the Risk Management arrangements within an organisation – sets out lines of communication and reporting, delegation, and roles / responsibilities.

Risk Assessment. The scoring of a risk to allow prioritisation. Determining the likelihood and impact of a risk.

Risk Champion. The person / role with responsibility within an individual department or business area for maintaining lines of communication with the Risk Management team, administering the risk register and co-ordinating all risk activities.

Risk Control. Management measures put in place to effectively manage a risk to within an acceptable level. Can be preventative or contingency in nature and will reduce the likelihood or impact of consequence.

Risk Culture. The reflection of the overall attitude of every part of management of an organisation towards risk.

Risk Target Score. An acceptable level of risk based on the category of risk and risk appetite.

Risk Escalation. The process of delegating upward, ultimately to the Board, responsibility for the management of a risk deemed to be impossible or impractical to manage locally.

Risk Lead. The person / role responsible for managing a risk on a day-to-day basis, assessing the risk score, and updating the management plan, reviewing the risk on a regular basis.

Risk Management. The integrated approach (culture, processes, structures) to the identification, analysis, control, and monitoring of risk.

Risk Management Policy. Statement outlining the objectives of the risk management practices within the organisation.

Risk Management Strategy. Sets out the basis for the principles, processes, and approaches to risk management to be followed in order to achieve a consistent and effective application of risk management and allow it to be embedded into all core processes.

Risk Matrix. A scoring mechanism used to identify the severity of a risk, using a multiplication of likelihood and impact, across pre-set categories.

Risk Maturity. The level of risk management capability within an organisation.

Risk Owner. The person / role with accountability for ensuring the effective management of a risk.

Risk Register. A tool used to capture and monitor risks. Includes all information required about that particular risk and is intended to be used both as a management tool and conduit for risk reporting.

Risk Tolerance. The maximum level of risk the organisation can tolerate regarding each type of risk before the organisation is significantly impacted.

Threat. A negative scenario which could give rise to risks.

Untreated Risk Score. The risk score identified by assessing the risk with no controls, mitigation, or contingency plans in place.

APPENDIX B: RISK ASSESSMENT MATRIX

Impact – What could happen if the risk occurred? Assess for each category and use the highest score identified.

The impact scale is from an organisational level perspective. It reflects the key areas that if impacted could prevent the organisation achieving its priorities and objectives. The scale is a guide and cannot cover every type of impact therefore judgement is required.

Category	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Patient Experience	Reduced quality patient experience/clinical outcome not directly related to delivery of clinical care	Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable	Unsatisfactory patient experience/ clinical outcome, short term effects – expect recovery less than 1wk Increased level of care/stay less than 7 days	Unsatisfactory patient experience /clinical outcome, long term effects - expect recovery over more than 1week Increased level of care/stay 7 -15 days	Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects
Objectives/ Project	Barely noticeable reduction in scope/quality/schedule	Minor reduction in scope/quality/ schedule	Reduction in scope/quality/project objectives or schedule	Significant project over-run	Inability to meet project/corporate objectives, reputation of the organisation seriously damaged
Injury /illness (physical and psychological) to patient/visitor/staff	Adverse event leading to minor injury not requiring first aid No staff absence	Minor injury or illness, first aid treatment required Up to 3 days staff absence	Agency reportable, e.g., Police (violent and aggressive acts) Significant injury requiring medical treatment and/or counselling	Major injuries/long term incapacity /disability (e.g., loss of limb), requiring, medical treatment and/or counselling	Incident leading to death(s) or major permanent incapacity

			RIDDOR over 7- day absence due to injury/dangerous occurrences	RIDDOR over 7- day absence due to major injury/dangerous occurrences	
Complaints/Claims	Locally resolved verbal complaint	Justified written complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim Complex Justified complaint
Service/ Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service with minor impact on patient care/service provision	Some disruption in service with unacceptable impact on patient care Temporary loss of ability to provide service Resources stretched Potentially impaired operating capability Pressure on service provision	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked Potentially impaired operating capability Temp service closure	Permanent loss of core service/ facility Disruption to facility leading to significant “knock on” effect -- Inability to function
Staffing and Competence	Short term low staffing level temporarily reduces service quality (less than 1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objective/service /care due to lack of staff	Uncertain delivery of key objective/service/care due to lack of staff	Non-delivery of key objective/ service/care due to lack of staff.

	Short term low staffing level (>1 day), where there is no disruption to patient care	Minor error due to lack of/ ineffective training/ implementation of training	Moderate error due to lack of/ ineffective training / implementation of training ongoing problems with staffing levels	Major error due to lack of/ ineffective training / implementation of training	Loss of key staff Critical error due to lack of/ ineffective training/ implementation of training
Financial (including Damage/Loss/Theft / Fraud	Negligible organisational/ personal financial loss up to £100k	Minor organisational/ personal financial loss of £100k - £250K	Significant organisational/personal financial loss of £250k - £500k	Major organisational/personal financial loss of £500k - £1m	Severe organisational financial loss of more than £1m
Inspection/ Audit	Small number of recommendations which focus on minor quality improvement issues	Recommendations made which can be addressed by low level of management action	Challenging recommendations that can be addressed with appropriate action plan Improvement Notice	Enforcement/prohibition action Low Rating Critical report	Prosecution Zero rating Severely critical report
Adverse Publicity/ Reputation	Rumours, no media coverage Little effect on staff morale	Local media coverage – short term Some public embarrassment Minor effect on staff morale/public attitudes	Local media - long-term adverse publicity Significant effect on staff morale/public perception of the organisation	National media adverse publicity less than 3 days Public confidence in the organisation undermined Use of services affected	National/International media/ adverse publicity, more than 3 days MSP/MP/SEHD concern (Questions in Parliament)

			Local MSP/SEHD interest		Court Enforcement/Public Enquiry/FAI
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Likelihood – What is the likelihood of the risk occurring? Assess using the criteria below.

Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
It is assessed that the risk is <u>very unlikely</u> to ever happen.	It is assessed that the risk is <u>not likely</u> to happen.	It is assessed that the risk <u>may</u> happen.	It is assessed that the risk is <u>likely</u> to happen.	It is assessed that the risk is <u>very likely</u> to happen.
Will only occur in exceptional circumstances	Unlikely to occur but potential exists	Reasonable chance of occurring - has happened before on occasions	Likely to occur - strong possibility	The event will occur in most circumstances

Risk Assessment Table – Multiply likelihood score by impact score to determine the risk rating (score).

LIKELIHOOD	5	Medium 5	High 10	High 15	Very High 20	Very High 25
	4	Medium 4	Medium 8	High 12	High 16	Very High 20
	3	Low 3	Medium 6	Medium 9	High 12	High 15
	2	Low 2	Medium 4	Medium 6	Medium 8	High 10
	1	Low 1	Low 2	Low 3	Medium 4	Medium 5
		1	2	3	4	5
		IMPACT				

Review Timescales – When a risk rating has been assigned the criteria below should be used to assess the review timescales.

Very High or High	Requires monthly monitoring and updates.
Medium	Requires quarterly monitoring and updates.
Low	Requires quarterly monitoring and updates.

FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

6.4 Strategic Risk Register – Q3 2021/22 Update For Approval

Executive Sponsor: Mr Scott Urquhart, Director of Finance

Author: Ms Kerry Mackenzie, Head of Policy & Performance

Executive Summary

The enclosed report presents an update to the Strategic Risk Register for Quarter 3 2021/22.

Recommendation

The Forth Valley NHS Board is asked to:

- **consider** the assurance provided regarding the effective management and escalation of Strategic Risks
- **approve** the proposed changes to the Strategic Risk Register for Quarter 3 2021/22

Key Issues to be Considered

Effective Risk Management is a fundamental cornerstone of good Corporate Governance and Internal Control and is an essential component in the delivery of the NHS Board's corporate objectives.

The Board of NHS Forth Valley is corporately responsible for this Risk Management Strategy and for ensuring that significant risks are adequately controlled. The NHS Board Assurance Committees principally, Audit and Risk, Performance and Resources, Clinical Governance and Staff Governance are responsible for various aspects of risk management. All Assurance Committees are responsible for monitoring the effective and efficient management of risks relevant to their areas of responsibility. The Audit Committee has a responsibility for overseeing the operation of the risk management strategy as distinct from the management of specific risks.

There is an agreed escalation process in place to ensure significant risks identified that are unable to be effectively managed by a local team or function, are escalated appropriately following the NHS Board's line management arrangements. The nature of risks that may need to be escalated include, for example:













- Significant threat to achievement of Government objectives and/or standards
- Assessed to be a substantial or intolerable risk
- Widespread beyond local area span of control
- Significant cost of control beyond scope of budget holder
- Potential for adversely impacting on the reputation of the organisation and the services it provides

Since the previous review of the Strategic Risk Register, approved by NHS Board in November 2021, there is one proposed change for the Quarter 3 Reporting Period:

- **SRR016: Out of Hours Service – New risk.** Lack of adequate staffing levels have impacted on the ability to ensure a staffed clinical rota. This has affected the ability to deliver a fully functioning Out of Hours Service (OOHS). It is recommended as a new strategic risk.

Active Risks

There are 12 active strategic risks: 7 Very High, 5 High. These are listed detailed in Table 1 below.

Code	Current Corporate Risks	Current Score	Target Score	Direction of Travel
SRR.001	If there is insufficient funding and recruitment, there is a risk that NHS FV will not implement the Primary Care Improvement Plan, resulting in an inability to fulfil the Scottish Government Memorandum of Understanding as part of the GP contract, jeopardising GP practice sustainability and potential financial penalty for non-implementation	12	6	
SRR.002	If NHS FV fails to deliver on the 6 Essential Actions Improvement Programme there is a risk we will be unable to deliver and maintain appropriate levels of unscheduled care, resulting in service sustainability issues and poor patient experience (including the 4 hour access standard).	25	9	
SRR.003	If NHS Forth Valley fails to implement effective Information Governance arrangements there is a risk we will not comply with a range of requirements relating to GDPR and the Network and Information System Regulation (NIS), resulting in reputational damage and potential legal breaches leading to financial penalties	16	9	
SRR.004	If there are delays in delivery of scheduled care there is a risk that NHS FV will be unable to meet its obligations to deliver the National Waiting Times Plan targets for 2020-21, resulting in poor patient experience and outcomes	20	9	
SRR.005	If NHS FV financial plans are not aligned to strategic plans and external drivers of change, there is a risk that our cost base for our services over the medium to long term could exceed our future funding allocation, resulting in an inability to achieve and maintain financial sustainability, and a detrimental impact on current/future service provision	20	9	
SRR.009	If NHS FV does not implement effective strategic workforce planning (including aligning funding requirements) there is a risk that we will not have a workforce in future that is the right size, with the right skills and competencies, organised appropriately within a budget we can afford, resulting in sub-optimal service delivery to the public.	16	6	
SRR.010	If there is insufficient Capital funding to develop and improve the property portfolio there is a risk the Estate and supporting infrastructure will not be maintained in line with national and local requirements.	20	9	
SRR.011	If there are significant technical vulnerabilities there is a risk the NHS FV IT Infrastructure could fail, resulting in potential major incidents or impact to service delivery	12	6	
SRR.012	If NHS FV does not deliver an effective re-mobilisation plan in response to COVID-19 there is a risk we fail to manage demand on services and miss opportunities for long term change / improvement	20	6	
SRR.014	If the planned review of the NHS Forth Valley Healthcare Strategy (2016-2021) does not incorporate learning from the COVID-19 pandemic and does not align with government policy and / or Integration Authorities Strategic Commissioning Plans there is a risk the Board's vision, corporate objectives and key priorities will be incorrect, resulting in services that are not sustainable in the long term and an inability to deliver transformation	15	3	
SRR.015	If NHS Forth Valley does not build and maintain effective cyber resilience, there is a risk that the cyber security of the organisation may be compromised, resulting in disruption to our ICT systems and service delivery. Increased Cyber risk as reported by National Cyber Competent authorities (NCSC, SG Cyber Unit)	20	16	
SRR.016 NEW	If NHS Forth Valley is unable to provide a fully staffed and functioning OOHS, there is a risk of instability within the service leading to an inability to provide robust and timely care to patients.	20	9	

- The full Strategic Risk Register is noted at Appendix 1

Financial Implications

There are no financial implications associated with this paper.

Workforce Implications

There are no workforce implications associated with this paper.

Risk Assessment

Subject of the paper.

Relevance to Strategic Priorities

Risk Management is an essential tool in supporting the organisation to achieve its strategic objectives and implement management arrangements to mitigate threats to those objectives.

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.


Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity


Consultation Process

- One-to-one risk review meetings with Risk Owners and Risk Leads during the period January to March 2022.
- Endorsement by Audit & Risk Committee: 25 March 2022


Strategic Risk Register

Ref	ID Date	Risk Title	Risk Description	Untreated Likelihood	Untreated Impact	Untreated Score	Current Controls In Place	Current Likelihood	Current Impact	Current Score	Current Risk Trend	Further Controls Required	Further Control Target Date	Target Likelihood	Target Impact	Target Score	Last Updated	Review Notes	Risk Owner	Risk Lead
SRR.002	03-Dec-2020	Unscheduled Care	If NHS FV fails to deliver on the 6 Essential Actions Improvement Programme there is a risk we will be unable to deliver and maintain appropriate levels of unscheduled care, resulting in service sustainability issues and poor patient experience (including the 4 hour access standard).	5	5	25	Unscheduled Care Programme Management Office established to ensure consistent approach to improvement and governance of the programme.	5	5	25		Implementation of transformational opportunities in unscheduled care	31-Dec-2022	3	3	9	15 Mar 2022	The UCDG now meeting and programme board also. The ADHOC oversight group ran from October - to January and has now stood down following improvements in performance.	Andrew Murray; Arlene Stewart	Sankara Langley; Phyllis Wilkieson
							Unscheduled Care Programme Board re-focus in line with UC PMO governance.					Establish same day emergency care approach within UCC	31-Mar-2022							
							Unscheduled Care Programme Board co-chaired by Medical Director and Chief officers from both HSCPs to provide whole system governance of unscheduled care developments.					Quality Improvement Team to support Criteria Led Discharge; Access metrics dashboards; improvement to internal processes in ED	31-Mar-2022							
							6 EA Programme Management structure and associated resources in place - Programme Manager and further resources for unscheduled care made available through RUC					Implementation of 7 day working for AHPs to support flow and address admission / discharge imbalance at FVRH at weekends	31-Mar-2022							
							Unscheduled Care Delivery Groups established, reporting to UCPD and in line with new Scottish Government Unscheduled Care programme - 3 workstreams established: Access; Optimise; Transfer					Establish a Whole System High Impact Action Plan for 30-60-90 days for early 2022.	31-Mar-2022							
							Establishment of a weekly Adhoc Unscheduled Care Oversight Group to progress the Scottish Government Work.					Flow 3 Workstream with Scottish Government	31-Mar-2022							
							Establishment of Flow Navigation Hub, building on Call MIA, to ensure patient is directed to the most appropriate service in an appropriate timeframe - this redirection can include access to a Senior Clinical Decision Maker to ensure most appropriate direction and avoiding unnecessary attendance and waits in ED or MIU.													
							Development of Flow Navigation Hub into a whole system unscheduled care operational centre													
							Establishment of Urgent Care Centre to include a range of services that can be more appropriate provided outwith an ED (e.g. MIU, AHP, Pharmacy,													


[illegible]

Ref	ID Date	Risk Title	Risk Description	Untreated Likelihood	Untreated Impact	Untreated Score	Current Controls In Place	Current Likelihood	Current Impact	Current Score	Current Risk Trend	Further Controls Required	Further Control Target Date	Target Likelihood	Target Impact	Target Score	Last Updated	Review Notes	Risk Owner	Risk Lead
SRR.004	03-Dec-2020	Scheduled Care	If there are delays in delivery of scheduled care there is a risk that NHS FV will be unable to meet its obligations to deliver the National Waiting Times Plan targets for 2020-21, resulting in poor patient experience and outcomes	5	4	20	Acute Service Directorate has, as part of the recovery process, reorganised scheduled care. Clinical leadership has been incorporated into the delivery structure. A local Scheduled Care Delivery Group has been established which is chaired by the Associate Medical Director for Scheduled Care. Clinical Directors and Clinical Leads attend along with operational managers.	5	4	20		Apply Realistic Medicine principles to Scheduled Care	31-Mar-2022	3	3	9	22 Mar 2022	<p>The Scheduled Care Delivery Group has unfortunately not been able to meet, due to pandemic pressures in the system. Deployment matrix has not been progressed due to service pressures in response to the pandemic and after DMD delivered presentation to Performance & Resources Committee on 31/8/21.</p> <p>Deputy Medical Director to further present to Performance & Resources Committee in April 2022. The impact of long waiting times and the issues of potential harm previously highlighted to be discussed along with progress made to date in tackling long waits.</p> <p>Risk element of work to implement a performance management framework aligned with the risk management strategy in terms of how risks are being managed paused whilst recruitment to post of Corporate Risk Manager. Anticipated start, end April 2022.</p> <p>Covid-19 risk to be incorporated across the strategic risk profile with this explicit within the Scheduled Risk.</p> <p>Costed activity plan for 2022/2023 requested by Scottish Government colleagues. Draft submitted in February 2022. Work with teams and Scottish Government ongoing to inform final draft.</p> <p>Increase in diagnostics to support discharge of patients from the front door preventing admission whilst ensuring inpatient and outpatient activity continues.</p> <p>Clinical prioritisation of patients with routine patients seen in date order.</p> <p>Internal Audit of Scheduled Care Risk to be undertaken with a particular focus on the management of the risk in relation to deferred treatment. Draft audit plan</p>	Cathie Cowan	Stephanie McNairney; Phyllis Wilkieson


[illegible]

Ref	ID Date	Risk Title	Risk Description	Untreated Likelihood	Untreated Impact	Untreated Score	Current Controls in Place	Current Likelihood	Current Impact	Current Score	Current Risk Trend	Further Controls Required	Further Control Target Date	Target Likelihood	Target Impact	Target Score	Last Updated	Review Notes	Risk Owner	Risk Lead
SRR.005	03-Dec-2020	Financial Sustainability	If NHS FV financial plans are not aligned to strategic plans and external drivers of change, there is a risk that our cost base for our services over the medium to long term could exceed our future funding allocation, resulting in an inability to achieve and maintain financial sustainability, and a detrimental impact on current/future service provision	5	4	20	Directorate financial projections regularly reviewed at Directorate and service meetings with budget holders to review any issues and projections	5	4	20		The Performance & Resources Committee Assurance Forward Planner and Assurance Plan provides a structure enabling identification, mapping and coordination of the main sources of assurance specific to the functions of the Committee, as detailed in its Terms of Reference.	01-Jan-2050	3	3	9	15 Mar 2022	A financial break-even position is projected for 2021/22 based on confirmed funding sources and current expenditure levels. Further work on cost improvement plans, supported by SLT colleagues and aligned to Covid recovery plans, has been progressed for 2022/23. The level of savings requirement for 2022/23 is quantified at £29.4m and brings a significant level of challenge to maintain financial break even on a recurring and sustainable basis.	Scott Urquhart	Simon Dryburgh
							Integration Authorities budget setting process agreed before each new financial year					Delivery of a range of transformation programmes and projects to achieve savings targets	31-Dec-2021							
							Five Year Financial Plan in place linked to annual delivery plan informed by service, workforce plans and budget setting process					Conclude arrangements for development of a capacity and financial model to support Set Aside budget	01-Oct-2022							
							Infrastructure Programme Board in place and being led by DOF					Create capacity for Finance team to better support business decisions and priorities for senior service managers through structured improvement workstreams	30-Jun-2022							
							Fortnightly senior finance meetings, including attendance from IA Chief Finance Officers to ensure regular communication and planning.					Business Partnering Training is being rolled out across the Finance Team	31-Mar-2022							
							National monthly Finance Directors meetings in place to update on strategic financial issues as well as COVID-19 related costs and issues.					Update recurring Cost Improvement Plans with clear process for pipeline developments, and governance arrangements to oversee delivery.	30-Apr-2022							
							National monthly Corporate Finance Network group meetings in place - implementation of operational finance management and current issues and feeds to National Finance Directors meetings					Refresh SLT Terms of Reference to clarify in-year investment and disinvestment prioritisation process.	01-May-2022							
							CPMO established and resourced to deliver transformation programmes to achieve savings targets with overarching Cost Improvement Board established to meet bi-monthly.					Further roll out of value management collaborative approach in line with plans	01-Aug-2022							
							Standing Financial Instructions in place underpinned by Financial													


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SRR.010	03-Dec-2020	Estates and Supporting Infrastructure	If there is insufficient Capital funding to develop and improve the property portfolio there is a risk the Estate and supporting infrastructure will not be maintained in line with national and local requirements.	5	4	20	Infrastructure developments prioritised and funded through the NHS Board capital plan.	5	4	20		The Performance & Resources Committee Assurance Forward Planner and Assurance Plan provides a structure enabling identification, mapping and coordination of the main sources of assurance specific to the functions of the Committee, as detailed in its Terms of Reference.	01-Jan-2050	3	3	9	25 Jan 2022	A great deal of progress has been made in relation to the Masterplan/Strategic Assessment for Falkirk Community Hospital and the Initial Agreement for Primary Care Premises. The Strategic Assessment was completed on time and is in final review phase prior to going through 'internal' governance and submission to the Chair of the Capital Investment Group. The Initial Agreement is substantially complete bar financial information and drafting should be complete by end January/early February. The overarching Programme Board is yet to meet and at the time of this review, plans were being made for this to happen in mid-February 2022.	Jonathan Procter	Morag Farquhar
							Regular Property and Asset Management Strategy (PAMS) report submitted to Government.					Establish Programme governance structure for FCH and GP premises review via CPMO	28-Feb-2022							
							Operational condition of estate regularly assessed and monitored through the Estates Asset Management System.					Complete Strategic Assessment for Falkirk Community Hospital site for submission through internal governance	04-Feb-2022							
							Annual review of the estate performance and condition monitored through the Performance and Resources Committee (PAMS reporting)					Complete Initial Agreement for Primary Care premises for submission through internal governance	04-Feb-2022							
							GP and Community Premises current condition and planning review completed to support capital priorities (rolling review).													
							Longer term planning for future accommodation requirements (linked to PAMS and GP premises review, FCH review).													
							Accommodation Options for Health Records drawn up in consultation with Health Records and other partners													
							Regular reviews with PPP partners for FVRH, SHCV, CCHC and planned preventative maintenance programmes in force including 'Blackstart'.													
							Compliance group established which reports to Infrastructure Programme Board, Health & Safety													


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SRR. 012	03-Dec-2020	COVID-19 Re-mobilisation	If NHS FV does not deliver an effective re-mobilisation plan in response to COVID-19 there is a risk we fail to manage demand on services and miss opportunities for long term change / improvement	4	5	20	Mobilisation plans prepared and enacted across services.	4	5	20		The Performance & Resources Committee Assurance Forward Planner and Assurance Plan provides a structure enabling identification, mapping and coordination of the main sources of assurance specific to the functions of the Committee, as detailed in its Terms of Reference.	01-Jan-2050	3	2	6	16 Mar 2022	RMP4 Submitted to SG on 7 October building on RMP3. Letter received from NHS Scotland Chief Operating Officer on 19 November 2021 highlighting Plan should be taken through local governance processes. The System-Wide Remobilisation Plan October 2021 to March 2022 was approved by the NHS Board on 30 November 2021 and published on the NHS Forth Valley website. RMP4 Deliver Plan Quarter 3 update submitted to Scottish Government per guidance received. Quarter 4 update to be submitted at the end of April 2022. Draft costing elective activity plan 2022/2023 submitted to Scottish Government. Final Submission due March 2022.	Cathie Cowan	Janette Fraser; Nicola Watt
							Tabletop exercises in place to test robustness of plans.					Continue existing Test and Protect regime	30-Apr-2022							
							Weekly SLT meetings to coordinate actions and dedicated management support structure in place					Delivery framework being drafted nationally that will set out the NHS Recovery Plan and a wider set of health and care deliverable will be delivered. His work is on-going with guidance awaited.	01-Aug-2022							
							Regular cost information shared with Scottish Government													
							Full engagement with staff side colleagues													
							Staff wellbeing resources in place													
							Additional workforce recruited (test and protect; testing centres; flu immunisation programme)													
							Local and national PPE updates to control stocks													
							Daily metrics update shared and circulated with weekly/monthly monitoring and circulation of the position against the Recovery Plan.													
							Support mobilised for care homes aligned to assurance and assessment Testing in place													
							Daily Acute Services huddles													
							Regular comms and working between Acute services and Partnerships													
							Risk assessments in place													

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SRR.015	09-Sep-2021	Cyber Resilience	If NHS Forth Valley does not build and maintain effective cyber resilience, there is a risk that the cyber security of the organisation may be compromised, resulting in disruption to our ICT systems and service delivery. Increased Cyber risk as reported by National Cyber Competent authorities (NCSC, SG Cyber Unit)	5	5	25	Digital and eHealth Strategy outlining resilience and cyber security plans approved by Health Board	4	5	20		The Performance & Resources Committee Assurance Forward Planner and Assurance Plan provides a structure enabling identification, mapping and coordination of the main sources of assurance specific to the functions of the Committee, as detailed in its Terms of Reference.	01-Jan-2050	4	4	16	17 Mar 2022	CURRENT CONTROLS - We are now in year 2 of the 3 year activity plan. Review of recommendations from 2021 audit completed, recommendations reported to governance groups, progress is kept up to date on a monthly basis (ongoing and will be implemented as a current control). Funding for cyber resilience solution granted and is due to be implemented - This protects us from business resilience and continuity Dec22. Corporate management team completed the cyber awareness session on the 7Oct21. Cyber security awareness communications strategy implemented during cyber Scotland week 6March22. FURTHER CONTROLS - Supplier management process to be improved in relation to cyber security 31march23 - progress updated and reviewed in July22 and report received in Nov22 once quality assurance step is completed by SG. CURRENT SCORE - Current score unchanged due to current situation in Ukraine/Russia and lack of implemented cyber resilience solution which has been resourced. Once implemented this would have a significant beneficial impact on the impact score.	Andrew Murray; Jonathan Procter; Arlene Stewart	Scott Jaffray; Phil Penman
							Cyber security objectives and initiatives included in the annual programme of work					Review and progress implementation of recommendations from annual NIS audit (2021)	31-Oct-2022							
							National deal struck for Windows 7 security patches beyond Jan 2020(7) for 12 months. GPIT Programme Board drafted risk assessment					Cyber Security Awareness raising and communications strategy to be implemented	31-Mar-2022							
							Infrastructure PB supported CISCO software and security system rolled out 2021					Improvement of supplier management procedures relevant to cyber security. Supplier management process to be improved in relation to cyber security 31st March 2023 and progress updated and reviewed in July 2022, report received in November 2022 once quality assurance check is completed by SG.	31-Mar-2023							


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SRR. 016	16-Mar-2022	Out of Hours Service (OOHS)	If NHS Forth Valley is unable to provide a fully staffed and functioning OOHS, there is a risk of instability within the service leading to an inability to provide robust and timely care to patients.	5	4	20	Reviewing the rota on a weekly basis and highlighting key shifts where gaps are evident, implementing coverage in all areas where the availability of staff is low.	5	4	20		Working with the Scottish Ambulance service to implement a routine regular feature of support at weekends which would diminish the overhaul of late or missed home visits as ambulance resources are available.	31-Oct-2022	3	3	9	18 Mar 2022	The Out of Hours Service (OOHS) are exposed to a number of risks associated with the overall provision of care provided to patients. There is a lack of adequate staff levels to cover the clinical rota, resulting in service interruption as patients will not receive home care within the targeted time, placing NHSFV at risk of providing tarnished patient experience and furthermore resulting in complaints. OHHS staffing levels are also impacted by normal sickness related absences and COVID-19 related absences, straining the timely services and increasing risk exposure. OHHS are also experiencing organisational change and therefore adding further complexities internal to the service.	Judith Rooney; Karyn Webster	
							The development of clinical nurse advisors in the urgent care department to work with the OHHS team.					The opportunity for recruiting - Advertising for the recruitment of GP's and advanced practitioners.	31-Oct-2022							
							Co-ordinating with partner teams such as the clinical nurse advisors in urgent care, the Scottish Ambulance services who support OHHS at weekends with clinicians to improve the timely services.													


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SRR.003	03-Dec-2020	Information Governance	If NHS Forth Valley fails to implement effective Information Governance arrangements there is a risk we will not comply with a range of requirements relating to GDPR and the Network and Information System Regulation (NIS), resulting in reputational damage and potential legal breaches leading to financial penalties	5	4	20	Mandatory Information Governance training in place for all staff	4	4	16		The Performance & Resources Committee Assurance Forward Planner and Assurance Plan provides a structure enabling identification, mapping and coordination of the main sources of assurance specific to the functions of the Committee, as detailed in its Terms of Reference.	01-Jan-2050	3	3	9	20 Jan 2022	<p>UKGDPR/DPA Compliance Audits are now part of routine departmental duties.</p> <p>UKGDPR self assessments being undertaken ahead of ICO audit agreed to take place during Q2 2022.</p> <p>UKGDPR Gap analysis is now part of associated Data Protection sections within departmental work plan.</p> <p>Vulnerability Management solution delayed slightly due to technical issues with deployment. First reports anticipated by end of March 2022. Control target date amended.</p> <p>M365 governance and security has improved slightly due to recruitment to key posts. Planned removal of third party applications and other protective measures e.g. sensitivity labels still ongoing.</p> <p>OneTrust Implementation delayed due to national reconfiguration of platform tenancy and DPIA templates taking longer than anticipated. Target date has been amended.</p> <p>Information Sharing and Data Processing Agreements now handled under standard working practices and added to current controls in place.</p> <p>Security Information and Event Management solution deployed. This will be continually reviewed and changed to suit local monitoring requirements.</p>	Andrew Murray; Arlene Stewart	Deirdre Coyle; Phil Penman
							GDPR compliance workplan monitored through IGG					Implementation of a Vulnerability Management Solution	31-Mar-2022							
							NIS and DPA / GDPR supporting policies in place					Delivery of Cyber Security Awareness training and information	31-Mar-2022							
							Privacy Notices developed/agreed and displayed in public areas and web site					Implementation of OneTrust - DPIA management	30-Sep-2022							
							Incident reporting process in place						31-Mar-2023							
							Privacy Breach detection system in place and being audited													

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SRR.009	03-Dec-2020	Workforce Plans	If NHS FV does not implement effective strategic workforce planning (including aligning funding requirements) there is a risk that we will not have a workforce in future that is the right size, with the right skills and competencies, organised appropriately within a budget we can afford, resulting in sub-optimal service delivery to the public.	4	4	16	Submission of costed overarching workforce plan in line with annual plan to Scottish Government	4	4	16		3 year workforce plan to be established	31-Jul-2022	2	3	6	01 Feb 2022	Static. 3 year workforce plan on track to be submitted by end March 2022. Scottish Government issued a letter on 20th December, that the date for submission of the 3 year workforce has been extended to 31 July 2022. Further update on completion of the plan is expected imminently.	Linda Donaldson; Marian Smith	Elaine Bell
							Detailed demographic profiling completed due to age range of medical workforce in particular to inform recruitment plans					Joint HR / Finance service planning meetings to ensure affordability of 3 year workforce plan is taken into account throughout planning phase	31-Jul-2022							
							Developing service passed workforce plans in line with strategy and integration requirements													
							Regular workforce monitoring reports against WFP and Our People Strategy - Workforce Plan and People Strategy reviewed and reported to SGC quarterly													

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SRR.014	07-May-2021	Healthcare Strategy	If the planned review of the NHS Forth Valley Healthcare Strategy (2016-2021) does not incorporate learning from the COVID-19 pandemic and does not align with government policy and / or Integration Authorities Strategic Commissioning Plans there is a risk the Board's vision, corporate objectives and key priorities will be incorrect, resulting in services that are not sustainable in the long term and an inability to deliver transformation	4	5	20	Current Healthcare Strategy in place for 2016-2021 linked to national strategy / policy	3	5	15		National Elective Centre development providing additional capacity alongside local initiatives	31-Dec-2022	1	3	3	15 Mar 2022	CMT has been formed and meets monthly. Paper on Healthcare Strategy submitted to first meeting in July, verbal updates and papers issued to subsequent meetings. Culture and values events for staff scheduled of 24 and 25 March 2022. The outputs from the events will inform the healthcare strategy refresh. Stocktake complete and key findings presented to SLT. Further work on alignment to other local and national policy, plans and strategies undertaken and strategy map prepared. Summary of public and patient engagement in NHS and HSCP strategic plans and service developments since 2015 has been prepared.	Cathie Cowan	Janette Fraser
							COVID Remobilisation plans (3rd iteration) in place for Directorates / services and the Board as a whole					Review requirements and use of Strategic Deployment Matrices aligned to Healthcare Strategy	31-Dec-2022							
							Partnership Strategic Plans in place which run to 2022					Work with Partnerships in collaboration to ensure alignment of strategies and plans	30-Sep-2022							
							Regional partnership mutual aid arrangements in place in response to COVID in order to continue delivering strategic priorities					Continue to work with stakeholders at SG and other Board Chief Executives to inform and influence strategy at a national level	30-Sep-2021							
							Cancer service plans responding to COVID to ensure ongoing delivery of strategic priorities. National and regional cancer delivery plans and mutual aid arrangements in place					Continue to work with Regional Planning Chief Execs meetings to inform Healthcare Strategy	30-Sep-2021							
							NHS Forth Valley Strategic Programme Boards in place responsible for delivery of key elements of the Healthcare Strategy (including strategic deployment matrices)					Culture and values events for staff scheduled for 24th and 25th March 2022. The outputs from the events will inform the healthcare strategy refresh.	30-Jun-2022							
							Mechanisms in place for performance reporting against key strategic priorities via Performance & Resources Committee and Board in order to provide assurance and/or escalation of issues													
							Primary Care Improvement Plan delivering significant improvement and resilience in GP services													
			Forward plan and timeline for Healthcare Strategy																	

							refresh complete. This includes scale and scope requirements of the strategy refresh.												
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SRR.001	01-Dec-2020	Primary Care	If there is insufficient funding and recruitment, there is a risk that NHS FV will not implement the Primary Care Improvement Plan, resulting in an inability to fulfil the Scottish Government Memorandum of Understanding as part of the GP contract, jeopardising GP practice sustainability and potential financial penalty for non-implementation	5	4	20	Primary Care Improvement Plan (iteration 3) agreed and endorsed by partners which delivers significant proportion of requirement.	4	3	12		Explore opportunities for resource sharing where there is clear whole system benefit (e.g. MSK physio; phlebotomy, MH)	31-Mar-2022	2	3	6	21 Mar 2022	Implementation has progressed in line with our PCIP plan with additional risk mitigations in place as described; in particular pro-active planning and use of slippage funding which has facilitated assurance for the remaining plan. Despite a revised MOU, there remains some ambiguity around some of the contractual definitions and future national funding to assure full delivery of the contract avoiding any transitional payments. It is therefore recommended to reduce risk score from 5x4=20 (Very High) to 4x3=12 (High).	Cathie Cowan	Kathy O'Neill
							Tripartite statement (as part of PCIP) outlines constraints / risks / challenges re full delivery of the plan.													
							Transfer of vaccination risk to Board													
							Governance structure for delivery in place - Implementation group; leadership group; workstreams. Reporting against progress etc (90 day reporting tool).													
							Investment in quality clusters and leads to ensure GPs and multidisciplinary teams (MDT) are informed and involved in primary/community care developments, quality improvement resources to support PCIP and patient safety implementation													
							Support focus on infrastructure, e.g Primary Care IT, premises													
							Targeted recruitment to build GP and MDT capacity and capability - promoted NHS FV as an employer of choice for Primary Care roles – e.g. ongoing investment in investors in people, promote i-matter, work to achieve gold healthy working lives rating, support CPD.													
							Strong working relationships between partners, PCIP steering group team, committees. Alternative / complementary sources of funding have been prioritised to support													

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SRR.011	03-Dec-2020	IT Infrastructure	If there are significant technical vulnerabilities there is a risk the NHS FV IT Infrastructure could fail, resulting in potential major incidents or impact to service delivery	4	4	16	Annual Digital and eHealth delivery plan prioritised, approved and monitored by the Programme Board and Senior Leadership Team	3	4	12		The Performance & Resources Committee Assurance Forward Planner and Assurance Plan provides a structure enabling identification, mapping and coordination of the main sources of assurance specific to the functions of the Committee, as detailed in its Terms of Reference.	01-Jan-2050	2	3	6	01 Feb 2022	As per email on 28/01/22. Asset Review updated as new control required.	Jonathan Procter	Scott Jaffray
							Lifecycle System matrix reviewed annually by the Digital and eHealth Programme Board to shape future investment plans					Implementation of ICT owned actions from NIS audit	31-Oct-2022							
							Cyber security objectives and initiatives included in the annual programme of work					Review Internal Audit COVID intelligence alerts for cyber and related issues and take appropriate mitigating action.	30-Dec-2022							
							Windows/Office Programme team in place.					Review WAN Bandwidth to reflect significantly increased use of VC/Teams/NearMe	31-Dec-2022							
							National deal struck for Windows 7 security patches beyond Jan 2020(7) for 12 months. GPIT Programme Board drafted risk assessment					As per update on the 28/01/22.	31-Dec-2022							
							Programme of work to upgrade ICT infrastructure at FVRH as part of 20/21 delivery commenced and on track for completion this FY													
							Infrastructure PB supported CISCO software and security system rolled out 2021													
							Resources required to discharge NIS audit recommendations scoped and paper supported by SLT and year 1 and 2 funding agreed as part of HB financial plan in March 2021													
							Cyber Security Group Re-established and focusing on rolling out control environments and training													

FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

**7.1 Pandemic Covid-19 Update
For Assurance**

Executive Sponsor: Mrs Cathie Cowan, Chief Executive

Author: Dr Graham Foster, Director of Public Health and Strategic Planning

Executive Summary

This paper provides an update on the current status of the Covid-19 pandemic and our local response. Dr Foster will also provide a brief verbal update at the meeting and cover any recent developments after papers have been distributed.

Recommendation

The Forth Valley NHS Board is asked to:

- **consider** this public health update describing overall progress with responding to the pandemic and the latest updates for Forth Valley

Key Issues

- The Scottish Government published a revised Framework for Covid in February 2022. The framework (appendix 1) sets out Scotland's approach to managing Covid-19 and its associated harms effectively for the long term as we prepare for the next phase of the pandemic.
- From the end of March 2022 patients with Covid-19 symptoms are no longer to be directed to the NHS 24 111 helpline service and will be advised to contact their GP in a return to pre-pandemic arrangements. NHS Inform will continue to maintain a Coronavirus section on its website which will be the fastest way to access Covid-19 specific health advice and information.
- As predicted, Omicron cases had increased very rapidly causing a high peak around Christmas 2021 although the combined impact of the national protection measures plus public caution and widespread use of Lateral Flow Device testing helped blunt the modelled pandemic wave which peaked in early January 2022.
- The current circumstances of a largely vaccinated population, public health measures and newly available treatments are causing Covid-19 to be a less severe disease with fewer Covid-19 related deaths and admissions to ITU.
- A new subtype of Omicron B.A2 which is s-gene positive has become the dominant type during March 2022. This subtype is more infectious than previous Omicron although it is not causing more severe illness or showing vaccine escape.
- There has been a significant surge in cases of Omicron B.A2 in March 2022 with estimated rates as high as 14,000 cases per day across Scotland and the Office for National Statistics suggesting more than 1 person in 14 having Covid-19 on any given day.
- A number of effective antiviral treatments are now available for Covid-19. These are available to identified high risk patients who contact a special helpline if they test Covid positive.
- There continues to be very high pressure on NHS services across the country due to a combined effect of high levels of hospital admissions and staff absences.

- Social care and care at home services continue to be very stretched by demand and also very challenged by staffing levels. This is causing further pressure through delays to discharge for those who no longer require hospital inpatient care.
- While some vaccinated individuals experience milder symptoms or remain asymptomatic many still experience a severe flu like illness lasting 7-10 days. Fortunately, few cases appear to require inpatient care. Vaccinated individuals can still transmit Covid-19 to others.
- The Covid passport scheme for businesses and other premises ended on 28 February 2022.
- All International travel restrictions for people coming into Scotland ended at 4am on 18th March 2022. Passenger locator forms are no longer required and people who are not fully vaccinated do not have to take Covid-19 tests before and after travelling to the UK.
- NHS Forth Valley's Test and Protect Service has been very busy during March 2022 but continues to work well and is seamlessly linked to health protection who manage more complex cases. The rolling average case numbers have increased again from around 350 per day at the time of the last NHS Board meeting with the team regularly managing around 700 cases per day.
- NHS Forth Valley maintains a minimum Test and Protect team of 32 contact tracers working 7.5hr shifts every day, seven days a week, covering 08.00 to 20.00. The service currently employs 35.64 WTE contact tracers plus 3.8 WTE staff in training and leadership roles on fixed term contract till September 2022. We have 3.4 WTE leaving at the end of March so the remaining core team through April will be 32.24 WTE. There are also 3.4 WTE staff on secondment from other NHS roles and 45 bank staff available to work regular shifts.
- Testing has been a key component of Covid-19 controls with a emphasis on home LFD testing before visiting high risk settings such as care homes and daily LFD tests for those who are close contacts of Covid-19 cases.
- The requirement to support local care homes is continuing and many local care homes have had to move to additional controls mainly due to detecting asymptomatic or mild illnesses cases amongst staff or residents. There have been few severe cases or deaths reported.
- Cases amongst school age children continue to be common although there is little evidence of spread actually occurring within classrooms. Support to local schools continues and we work in partnership with local education departments and school staff to implement the national guidance which involves keeping schools open by only isolating very close contacts of cases. Remote learning or whole class isolation has not been necessary this term although some schools face changes due to high levels of staff absence in the current surge.
- Continuing pressure on frontline NHS and social care services presents an ongoing challenge to the NHS Board, Health and Social Care Partnerships and local councils.
- NHS staff are affected by the current high levels of community transmission which is resulting in increased staffing pressures.
- On the 15 of March 2022 the FM made a statement to parliament setting out the ending of almost all remaining legal requirements with regard to Covid-19 controls. The statement confirmed the following changes: -
 - Legal requirements to wear face coverings on public transport and most indoor public settings will continue until at least early April due to the March surge in Covid-19 case numbers.
 - Remaining legal requirements for businesses and service providers to collect customer details for contact tracing, and to have regard to and take reasonable measures set out in Covid guidance, will end on Monday 21 March.
 - From 18 April people without COVID-19 symptoms will no longer be asked to take regular lateral flow tests.
 - From 18 April 2022 most people without symptoms will no longer be asked to take Covid-19 tests
 - From 18 April 2022 free lateral flow devices (LFDs) for the purposes of twice weekly routine testing will no longer be available for the general population but will continue to be free for any purpose for which testing continues to be advised – for clinical care, for health and social care workers and for people visiting vulnerable individuals in care homes or hospitals

- Until the end of April 2022, people with symptoms should still isolate and get a PCR test
- Vaccinated close contacts of someone with confirmed Covid-19 should continue to test daily for seven days with LFDs
- People who have symptoms of Covid-19 will still be able to book PCR tests in the usual way until 30 April 2022.
- From 1 May 2022, fixed PCR test sites will be closed and people with symptoms will no longer be advised that they need to seek a test. The public health advice for people who feel unwell will be to stay at home until they feel better, to reduce the risk of infecting other people.
- Routine contact tracing will end on 30 April 2022.
- On the 15 March 2022, the Scottish Government published a plan (appendix 2) setting out these updated Test & Protect plans for the endemic phase of Covid-19, and how we will manage the transition from the current testing position to the end steady state.
- The ability to respond in the event of new variants requires contingency to be maintained across Test and Protect capabilities. This includes a core contingency of LFD stocks, Mobile Testing Units, PCR testing capacity and the ability to rapidly sequence positive tests, and enhanced Health Protection teams in local Health Boards with retained skills in complex outbreak investigation and support from PHS experts in epidemiology.

Scottish Government Publications

The Scottish Government continues to publish daily updates and documents with guidance on a range of topics including weekly updates on national modelling, travel guidance and the route map out of lockdown. These are available at <https://www.gov.scot/coronavirus-covid-19/>

A National Data and Intelligence Network has been meeting throughout the pandemic and this work has supported both the publication of the weekly modelling updates and the publication of extensive data and information in dashboard form by Public Health Scotland.

https://public.tableau.com/app/profile/phs.covid.19/viz/COVID-19DailyDashboard_15960160643010/Overview

Financial Implications

Most elements of the Test and Protect response have had national funding as have the enhanced resources for the local Public Health team. Detailed information is being provided to the NHS Board through regular Finance reports. Contact Tracing staff contracts have been extended to September 2022 and funding for community testing is available until June 2022.

Workforce Implications

The core health protection service currently has five health protection nurses providing 4.2 WTE and six consultants (including the DPH). The lead health protection consultant and immunisation co-ordinator post remains unfilled having been unsuccessfully out to advert. The team also has two dental public health consultants (1 WTE), around 100 test and protect contact tracing staff providing cover of 32 staff per day and a dedicated data analyst. Three medically qualified clinical fellows have been recruited to provide additional Covid-19 cover and resilience between January and August 2022.

A core team of up to 32 contact tracers (supported and supervised by public health consultants) continue to work 12 hours a day on weekdays and eight hours at the weekend. Staffing details are described above. Work is underway to identify future deployment options for all staff as service needs change.

Additional staff groups including the HR Directorate have been trained in contact tracing and provide an immediate contingency reserve.

Additional investment in IT such as laptops has reduced the need for dedicated accommodation with the team mostly now following a remote working model.

Specialist health protection, public health and infection control nursing staff will continue to be required for the remainder of the pandemic and the recovery phase. Staff who have been devoted to health protection duties are now available to be redeployed to wider public health tasks across health improvement, health service improvement, screening programmes and community planning.

Risk Assessment

Risk assessments have been produced and reviewed. A summary of risks identified include:

- The situation continues to be closely monitored with measures adjusted in a phased manner.
- Staffing challenges and rapid changes are being managed with flexible models.
- There are always unknowns around how the pandemic will evolve and impacts of new treatments and vaccines.
- Contingency arrangements are to be maintained as there is a continuing risk of new variants.

Relevance to Strategic Priorities

This is relevant to the continued delivery of NHS Forth Valley's Strategic objectives and the Public Health Scotland Act 2008.

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity

Consultation Process

NHS Scotland remains on an emergency footing. The approach is overseen by the System Leadership Team, the Contact Tracing Implementation Group, and the Care Homes Assurance Oversight Group.



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





COVID-19

Scotland's Strategic Framework Update



February 2022

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First Minister's Foreword

It has been two long years since COVID-19 first arrived in Scotland and changed all our lives. In common with countries around the world, the toll of the pandemic in Scotland has been heavy and I send my condolences to everyone who has suffered loss and my gratitude to all those who have worked so hard and sacrificed so much.

That includes, of course, all those across our public health, healthcare and social care services who have been working unstintingly to protect lives for such a long time. It also includes those in public services, the third sector and businesses across the country who have gone above and beyond during the pandemic, often in very challenging circumstances, to keep going while helping to keep people safe.

The advent of Omicron – by far the most transmissible variant of the coronavirus that we have encountered so far – and the challenges it brought, was a salutary reminder that we need to remain both vigilant and prepared for further harmful variants, and to continue to manage the epidemic effectively, for as long as necessary.

However, against these challenges there has been cause for optimism too. A year ago, the level of infections we have faced over the past couple of months would have necessitated far greater restrictions on our lives. During this most recent wave, however, we managed to keep schools and most businesses open. And although we advised everyone to limit contacts and avoid unnecessary socialising, Christmas was still much more normal than the year before.

This was all made possible – even in the face of the more transmissible Omicron variant – as a result of extraordinary advances in science and technology over the past two years that are enabling a more sustainable response to the virus and therefore a return to greater normality.

These advances include the remarkable vaccination programme, with its unprecedented pace and breadth of roll-out, and the development of new treatments that will reduce the harm from this disease. All of these give us good reason to hope that we are now in a calmer phase of the pandemic, and on a path to the virus becoming endemic.

Further, although the economic impact of the pandemic and the emergent recovery from it has not been even across different sectors, with many still struggling, overall the economy has now recovered to its pre-pandemic level of output and unemployment is near record lows.

This update to our Strategic Framework for managing COVID-19 sets out our future plans as we prepare for a calmer phase and seek to sustain it.

In developing this future approach the Scottish Government has engaged extensively with stakeholders and considered carefully the proposals set out by political parties and other organisations. These underline the shared ambition to get the future approach to managing COVID-19 right, and demonstrate a degree of consensus, even if we will not agree on every aspect of it. I will seek the approval of Parliament for the approach set out in this document.

It is a statement of the obvious that we cannot remove all of the uncertainty about the future caused by this virus, but we do want to provide as much clarity as possible about our approach in the months ahead. In particular, we want to help people and organisations know what to do to manage COVID-19 effectively and sustainably, so that we have the best possible chance of returning to a much more normal way of life.

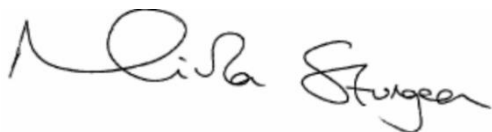
The Framework therefore makes clear that – thanks to the progress in vaccination and treatments – we intend to rely much less on legal requirements going forwards and much more on people and organisations taking basic, sensible steps to reduce the risk of and harm from COVID-19. This less restrictive approach will support the broad recovery and better future that we all want to see.

We know, however, that the threat of new variants that are potentially more harmful remains, and that we must be ready to respond effectively to such an eventuality so that we can mitigate the harm that might otherwise be caused. It is important that we share our thinking on how we will respond if the threat from the virus increases again in the future, so that people and organisations are able to plan ahead. By setting out new categories of risk (low, medium, high), the factors that will help us judge which of these we face at any given time, and potential measures that could be deployed in response to each, this document seeks to do that.

In addition, our work to support and enable recovery is already proceeding at pace, as part of our [COVID-19 Recovery Strategy](#) for Scotland.

We, as a government, will do what we need to do, working with partners and informed by the views of stakeholders, to ensure resilience and prepare for new variants or other future emergencies. We are committed to learning lessons from this epidemic to bolster our response to future crises. We will also co-operate fully with the COVID-19 Public Inquiry that is now underway.

As we look forward to 2022 with renewed optimism but also a sense of continued vigilance and resilience, no-one can guarantee a return to life exactly as it was in every respect before COVID-19. But through our collective efforts – and even though the road ahead may yet be challenging at times – we know that recovery and progress to a better future is now underway.

A handwritten signature in dark ink, appearing to read 'Nicola Sturgeon', with a stylized, flowing script.

Rt Hon Nicola Sturgeon MSP
First Minister of Scotland

Executive Summary

This update to our Strategic Framework takes stock of where we are in the pandemic and sets out our actions to respond to COVID-19 and its associated harms, and our approach to managing it effectively but also sustainably for as long as necessary.

As in countries across the world, the Omicron variant identified in November 2021 led to the highest rates of infection yet seen in Scotland, necessitating the deployment of temporary, targeted protective measures and support for sectors that were most affected. As that peak has subsided, though infection numbers are still high and pressures on the health and social care sector remain, we have been able to carefully but relatively quickly ease those measures.

We are now able to look forward to the rest of 2022 with increased optimism, albeit tempered by the need to remain prepared, vigilant and resilient given the ongoing uncertainties posed by this virus. While the recent high infection numbers led to some difficult challenges, our schools and most businesses remained open. And although the impacts on people, communities, businesses and other organisations have not been evenly felt – with some experiencing much greater hardships than others - our overall economic output has now recovered to its pre-pandemic level, and unemployment is close to record lows.

We hope that the epidemic will now move into a calmer phase, made possible by the remarkable progress on vaccination and in new treatments, which have both helped reduce the severity of the impact of the virus. COVID-19 remains a threat, but we are hopeful that this threat will continue to reduce as we head into the spring and summer.

In view of these positive developments, we are now updating our strategic intent from a focus on suppressing cases to managing COVID-19 effectively, primarily through adaptations and health measures that will strengthen our resilience and recovery. In the future, and as far as possible, we intend to rely much less on legal requirements and more on people and organisations making and sustaining the adaptations to behaviours and physical environments that will improve our resilience to the virus and help keep it in check.

For individuals and families this will include continued hygiene measures, improving ventilation, and wearing face coverings when and where appropriate (this may vary depending on levels of infection at different times). When we judge it is safe and prudent to do so, we will further relax guidance on self-isolation, and target testing for a narrower range of purposes – for example, to support ongoing surveillance, outbreak management, rapid response to new variants, and access to care and treatment for those most at risk. We intend to do this through a managed and phased transition.

For organisations, becoming more resilient to COVID-19 may include, for example, ensuring that sick pay and staffing practices are aligned with public health aims, adapting premises to make them safer for customers and staff, and enabling hybrid working where that makes sense and supports businesses and individuals.

This will not mean a return to conditions exactly as before the pandemic but it will help ensure that the impact of the virus on the trade and activities of businesses is much reduced.

We know, however, that while securing stability is crucial, the future path of the pandemic is uncertain and that the threat of new and potentially more harmful variants remains. We must therefore remain vigilant and ready to respond in a proportionate manner to any future threats, in order to mitigate the harm that they might otherwise cause.

The updated framework sets out our progress and the next steps we will take, working closely with partners, to deliver this approach. First and foremost, we will continue to consolidate and strengthen the vaccination programme. We will be informed by JCVI advice and draw on advances in vaccine technology – our objective is that everyone who will benefit from vaccination is able to receive it, and as regularly as recommended.

We will continue to deliver the necessary testing capability to enable ongoing surveillance – including genomic sequencing to allow the early identification of new variants, and effective public health responses – including self-isolation where appropriate, treatment and outbreak management. We will continue to gather, publish and analyse data – both nationally and internationally – to support our management of the epidemic.

We will seek to ensure that people have appropriate access to effective treatment for COVID-19, drawing on advances in technology and therapeutics. We will focus on improving mental health and wellbeing. And we will support those who are at higher clinical risk from COVID-19 and continue work to tackle health inequalities.

Given the ongoing uncertainty inherent in the pandemic, working with our partners, we will continue to develop and implement clear outbreak management plans, with appropriate supporting legislation and guidance, at institutional, local and national level so that people and organisations can understand what may be required and in what circumstances, and can respond accordingly.

We will be ready to respond to any increase in the threat posed by the virus, whether that comes from waning immunity, a new variant or other factors. We will apply careful judgement, taking all relevant factors into account, including the increased resilience that we expect to secure through adaptations and health measures.

We set out a clear framework of potential responses to assessed threats to provide as much clarity as possible for planning purposes, while retaining the necessary flexibility to ensure that responses are appropriately targeted. It is important to note that not all potential threats will be uniform in their impacts and our response must take account of all relevant factors. Our objective is to be targeted and proportionate.

The categorisation in Figure 1 below will guide future decisions. Deciding what 'threat' level should apply at any given time will involve both an assessment of data and the application of judgement. So too will determining what range of measures might be necessary in response (the measures outlined below are included for

illustrative purposes - it will not necessarily be the case that all of them are applied at each 'threat' level). What we have already learned, not least from the experience of Omicron, is that not all risks - e.g. new variants - will have the same impacts, so we cannot have a one size fits all response. For example, a new variant that is highly transmissible but of lower severity may represent less of a threat than one that is less transmissible but more severe. That is why setting fixed thresholds or triggers for action – e.g. a set number of cases per 100,000 population - would not be appropriate or helpful, as it would potentially result in either under or over reaction. Judgement about the nature and likely impact of any future risks will be key.

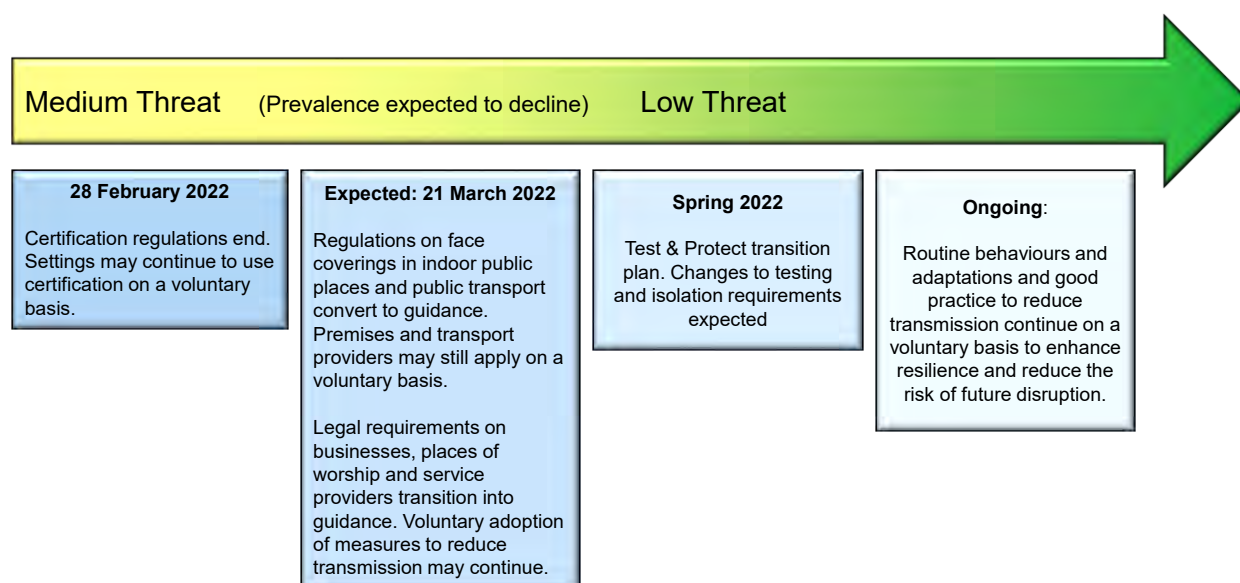
Figure 1: Potential Responses Categories for Future Threat Levels

Assessed Threat	Potential Response Categories (types of protective measure)	
Low threat	Routine Measures: Vigilance, Preparedness and Resilience (no legal measures) <ul style="list-style-type: none"> High immunity sustained through vaccination programme Access to effective treatments in line with clinical advice Behaviours and settings adapted to reduce spread (e.g. improved ventilation, appropriate guidance on face coverings) Hybrid working when possible and appropriate encouraged Effective and responsive local outbreak management Targeted testing and surveillance ongoing Travel measures may apply (e.g. set by other countries) 	Note: Protective measures would not apply in law but may still be good practice and retained in guidance.
	Medium threat	
High Threat	Baseline Protective Measures = Routine plus: <ul style="list-style-type: none"> Testing guidance in place for people when symptomatic or asymptomatic Guidance to self isolate when positive in place Face coverings required in indoor public places and on public transport Guidance on reasonable measures to reduce risk in premises Travel measures may apply Certification required in a narrow range of settings 	Note: Measures would be selected from this response category that were necessary and proportionate – not all may be required at the same time.
	Targeted Protective Measures = Baseline measures plus: <ul style="list-style-type: none"> Requirement to work from home where possible Proportionate restrictions on certain higher risk settings and activities Protective measures in other higher risk settings . Guidance to reduce social contacts and increase physical distancing where possible. International travel requirements and restrictions may apply in relation to some countries. Certification required in a wider range of settings 	Note: Measures would be selected from this response category that were necessary and proportionate – not all may be required at the same time.
(E.g. variant with significant immune escape that increases disease severity)	Extensive Protective Measures = Baseline and targeted measures plus: <ul style="list-style-type: none"> Potential closure (or limited opening) of further non-essential settings and services Legal limits on social gatherings and events. 	Note: 'Extensive protective measures' will only ever be considered as a last resort in the most serious of circumstances

We judge that our current situation – with a highly transmissible variant, resulting in a high level of infection, but with a lower severity of impact than previous variants - represents a medium threat. However, we consider that this will reduce in the coming weeks to a low threat, enabling us to lift the remaining legal measures in place. Should the threat level remain medium/low in the weeks ahead, it is therefore our intention to do so on the following timescale as set out in Figure 2:

- 28 February - COVID certification scheme will cease to be a legal requirement. The app will remain available to support any business wishing to implement a voluntary scheme.
- 21 March (*indicative date, to be confirmed at preceding review*) – the legal requirement to wear face coverings in public indoor places and on public transport will convert to guidance. Other remaining legal requirements will convert to guidance and good practice as appropriate.

Figure 2: Plans for changing legal requirements to guidance and good practice



As regulations are converted into guidance, we will ensure that clear information is in place to help people and organisations make and sustain the changes required to reduce transmission of the virus on a routine basis. This will involve maintaining and enhancing some of the behaviours and physical adaptations that have helped reduce transmission and will help to improve public health more generally going forwards.

More generally we will continue to work with sectors across the economy and broader society as we continue to mitigate the ongoing and accumulated harms of the crisis and, in parallel, as we collectively press forward with the recovery and transformation of our public services and rebuild for a better future. We know that COVID-19 has caused some in our society to experience greater harm, so we will seek to ensure that our actions do not exacerbate inequality, but improve outcomes instead. We outline here a range of activity that is helping to support our businesses, schools and other educational settings, social care, housing, transport, justice and other public services, consistent with our COVID-19 Recovery Strategy.

We know that sustainably reducing the harm from COVID-19 in Scotland also depends on what is happening with the pandemic internationally. We will apply proportionate travel measures – though only when necessary – and we will continue to work with partners in developing countries to enhance management of COVID-19 internationally and support the delivery of vaccines, treatment and surveillance.

We will continue to learn the lessons from COVID-19 to inform our thinking about possible future pandemics and other emergencies. We will co-operate fully with the public inquiries that are now underway in Scotland and the UK. And we will remember all those who have suffered and lost loved ones.

Though clear challenges remain on the road ahead, we are optimistic that with continued collective endeavour, and through vigilance, resilience and preparedness from people and organisations across Scotland, a prolonged calmer phase of the epidemic is in view, enabling us now to plan ahead with a greater sense of stability and confidence.

Overview

The last Strategic Framework update in November 2021 anticipated a challenging winter ahead, and noted the risk of a new variant. It underlined the need to remain cautious, even as we continued on a generally improving trajectory in our management of COVID-19. It set out the measures we were retaining to help keep people safe and noted that we would act quickly in response to deteriorating epidemiological conditions, such as a new variant.

That risk of a new variant materialised quickly. The Omicron variant was categorised as a Variant of Concern by the World Health Organisation (WHO) on 26 November. From the early data it became clear that Omicron had a significant growth advantage over Delta, the previous dominant variant in Scotland. Omicron is more able than Delta to infect people who have been vaccinated or who have had a previous infection. It has multiple genetic mutations that enable it to better evade antibodies and other immune responses developed through vaccination or natural infection.¹

Despite international efforts to slow the spread of the virus through targeted travel measures, Omicron quickly took hold in Scotland and around the world. It was first reported in Scotland on 29 November 2021 (based on a sample from 23 November), became the dominant strain on 17 December,² and led to a rapid escalation of cases (at a time of year when upward pressure on cases was likely even without a new variant). Cases peaked on 3 January 2022 at 16,407 weekly average PCR (polymerase chain reaction) confirmed cases per day - considerably higher than previous peaks.³

It was not clear in the early stages whether Omicron would be more or less severe in terms of disease than Delta. Subsequently, research has indicated that Omicron infections are generally less severe and less likely to result in hospital admission than Delta.^{4 5} Preliminary data from the UK Health Security Agency (UKHSA) indicate that the risk of attending hospital or emergency care is estimated at around half for Omicron compared to Delta, and the risk of being admitted to emergency care around one third of Delta.⁶

Notwithstanding the reduced severity of Omicron, given the sheer scale of cases, pressure on the NHS increased, on top of already significant general pressures. COVID-19 hospital admissions peaked at a seven day average of over 160 per day at the beginning of January 2022. This was at a similar level to the previous peaks in September 2021 (peaking at an average of over 160 per day) but lower than the peak in January 2021 (peaking at an average of over 200 per day), see Figure 3. Weekly average hospital occupancy for COVID-19 positive patients peaked at over 1,500 per day in mid-January 2022.⁷

¹ *12 January 2022 Risk assessment for SARS-CoV-2 variant: Omicron VOC-21NOV-01 (B.1.1.529)

² Omicron in Scotland - Evidence Paper (www.gov.scot)

³ Data available at [COVID-19 Daily Dashboard | Tableau Public](https://covid19.scot.nhs.uk/)

⁴ SARS-CoV-2 variants of concern and variants under investigation- Technical briefing 34

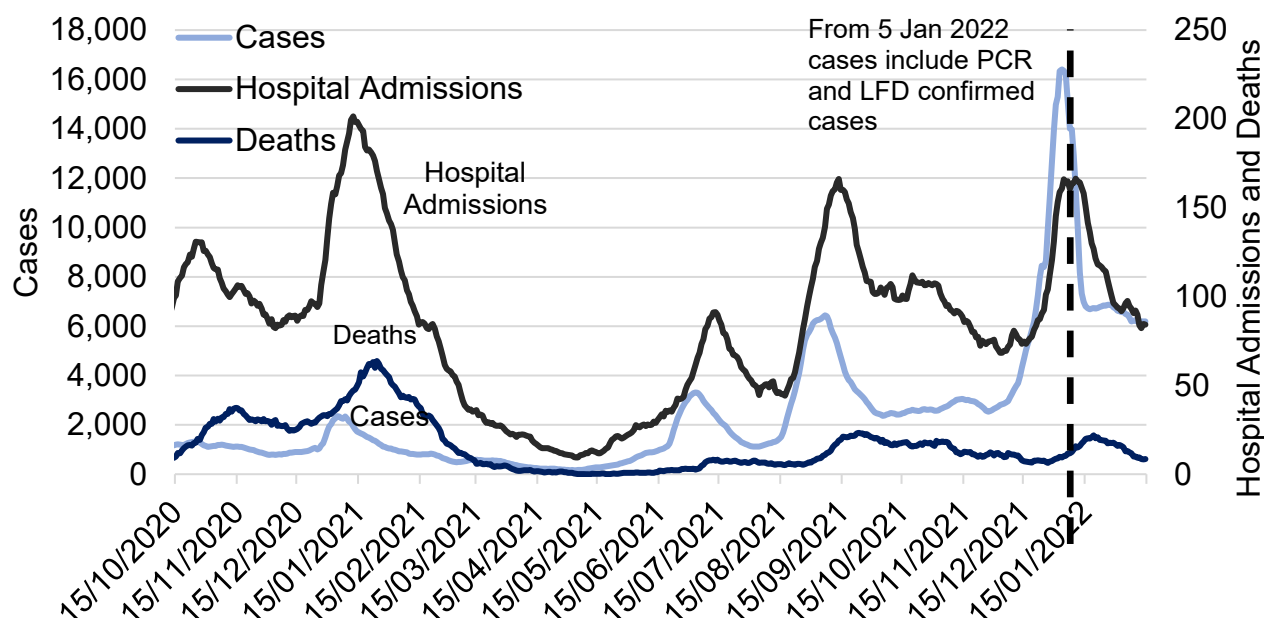
⁵ SAGE 102 minutes: Coronavirus (COVID-19) response, 7 January 2022 - GOV.UK (www.gov.uk)

⁶ SARS-CoV-2 variants of concern and variants under investigation (publishing.service.gov.uk)

⁷ Data available at [Coronavirus \(COVID-19\): trends in daily data - gov.scot](https://covid19.scot.nhs.uk/) (www.gov.scot)

The high number of infections also accentuated pressure on the COVID-19 testing system and led to a change in testing approach (those with no symptoms were no longer asked to take a PCR test to confirm a positive LFD test).⁸

Figure 3: COVID-19 case numbers, hospital admissions and deaths⁹



Consistent with the approach set out in the previous Strategic Framework, temporary, targeted protective measures were implemented as a proportionate response to the threats posed by Omicron. On 17 December 2021, legal requirements were introduced for businesses and other organisations to take reasonable measures to reduce transmission. Guidance was given to limit indoor socialising to three households with LFD testing before meeting. On 26 and 27 December 2021, restrictions on event capacity were introduced, one metre physical distancing was required in hospitality and leisure facilities, table service was required in hospitality where alcohol was served, and nightclubs were closed.

Another key part of our response to Omicron was to expand the booster vaccination campaign and accelerate the vaccine roll-out more generally. Eligibility for boosters was expanded to over 40s on 30 November, while 16-17 year olds were able to book their second dose. On 15 December, booster eligibility was further expanded to over 18s. Thanks to the unprecedented rates of vaccine take-up from people across Scotland, over 3.3 million people (70.6% of those over 12 years of age) have received their third dose or booster vaccine by 18 February 2022.¹⁰ Scotland is the

⁸ High prevalence reduces the chances of a positive LFD (lateral flow device) being a false result, so there is less need to do a confirmatory PCR.

⁹ Seven-day moving averages of cases by specimen (left-hand axis) and deaths and hospitalisation (right-hand axis). Source: Source: Weekly COVID-19 Statistical Data in Scotland - Datasets - Scottish Health and Social Care Open Data

¹⁰ Data available at [Public Health Scotland COVID-19 dashboard](https://publichealth.scot.nhs.uk/covid-19/dashboard/)

most vaccinated per capita of the four nations in the UK across first, second, third and booster doses.¹¹

In combination with people behaving more cautiously in response to the deteriorating situation, as evidenced in data including from the contact survey,¹² and with the increasing impact of booster vaccination, the additional, targeted measures helped to reduce the spread of Omicron in Scotland. They also limited the ensuing increase in morbidity and mortality from levels they might otherwise have reached.

Figure 4: Modelled weekly estimates of the percentage of the private residential population testing positive for COVID-19 in each of the four nations of the UK, between 7 November 2021 and 13 February 2022, including 95% credible intervals¹³

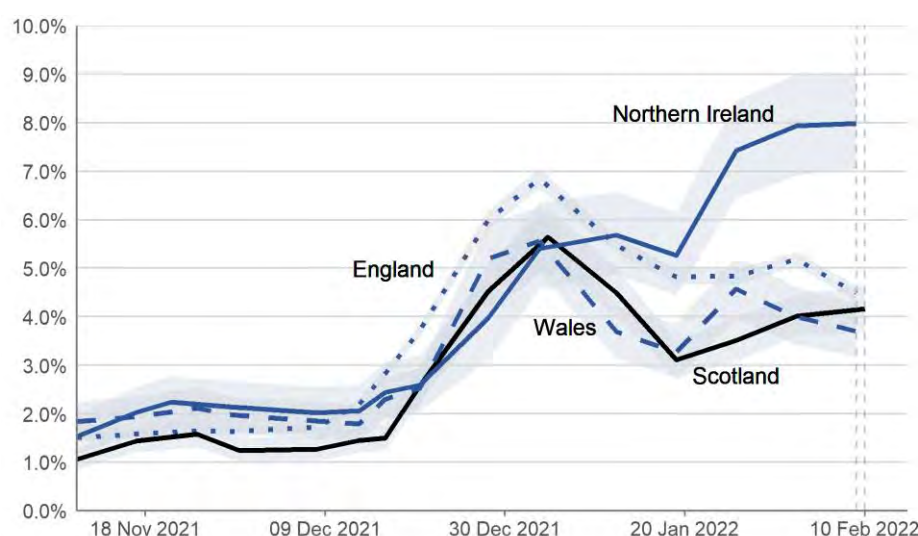
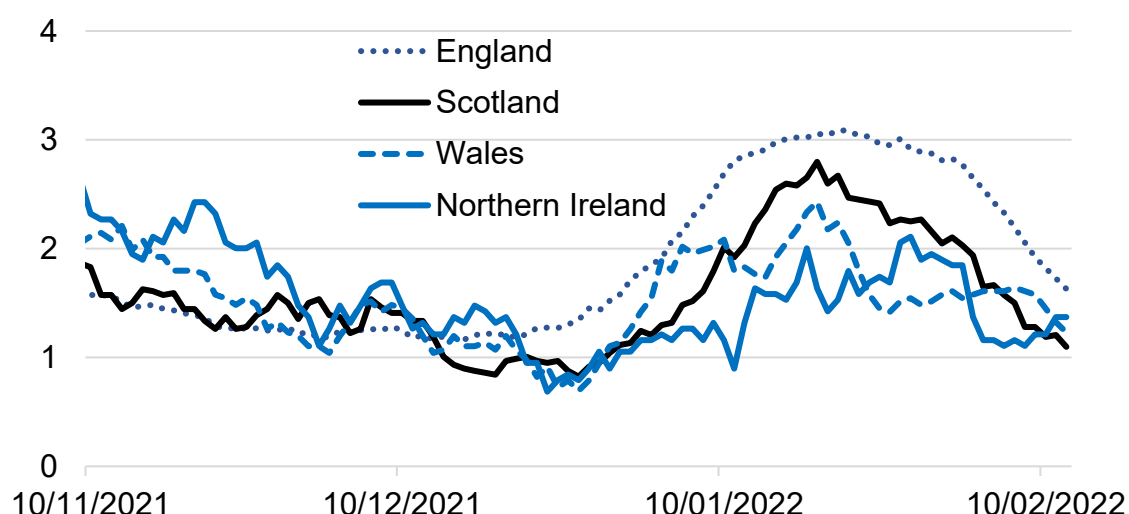


Figure 5: Weekly COVID-19 death rate per 100,000 (weekly average)



¹¹ [Vaccinations in the UK | Coronavirus in the UK \(data.gov.uk\)](https://data.gov.uk/dataset/vaccinations-in-the-uk)

¹² [Coronavirus \(COVID-19\): modelling the epidemic \(issue no.90\) - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/coronavirus-covid-19-modelling-the-epidemic-issue-no-90/pages/11/)

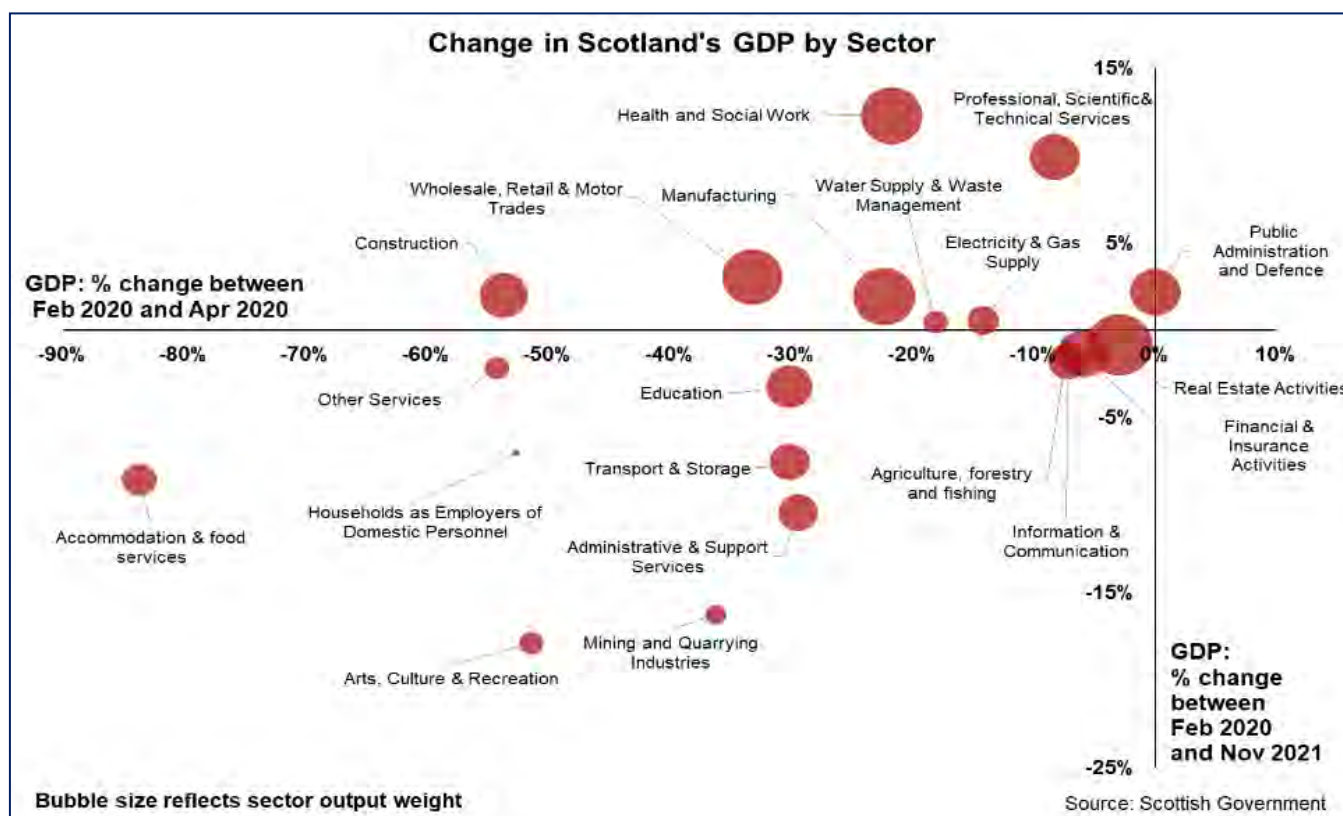
¹³ [ONS Covid Infection Survey](https://www.ons.gov.uk/covid19/surveys/ons-covid-infection-survey)

As can be seen in Figure 4, COVID-19 prevalence in Scotland peaked in early January and has since fallen, though it remains at a high level. The observed improvement has translated, following expected lags, into reduced hospital admissions and to reduced hospital and ICU occupancy. This has eased some of the most acute pressures on the NHS, though significant general pressures remain.

Once the peak in Omicron infections had passed and we were confident that infections were on a downward trajectory, we moved quickly to begin the phased easing of the temporary measures that had been put in place to provide extra protection against Omicron. Limits on largescale outdoor events were removed on 17 January 2022 alongside physical distancing requirements at outdoor event venues, outdoor exhibitions and outdoor spaces in sports stadia. The majority of the protective measures implemented after Christmas were lifted by 31 January, along with the guidance to limit socialising indoors to three households. The COVID-19 certification scheme was adjusted to permit the use of a negative test on 6 December and to add the requirement for a third dose on 17 January.)

Although economic and broader societal activities would have been curtailed by Omicron even in the absence of additional protective measures, as people exercised more caution, we acknowledge the impact of these measures on affected sectors. To support these sectors through this challenging period, we committed £375 million of additional financial support.

Figure 6: Change in Scotland's GDP by sector during the pandemic

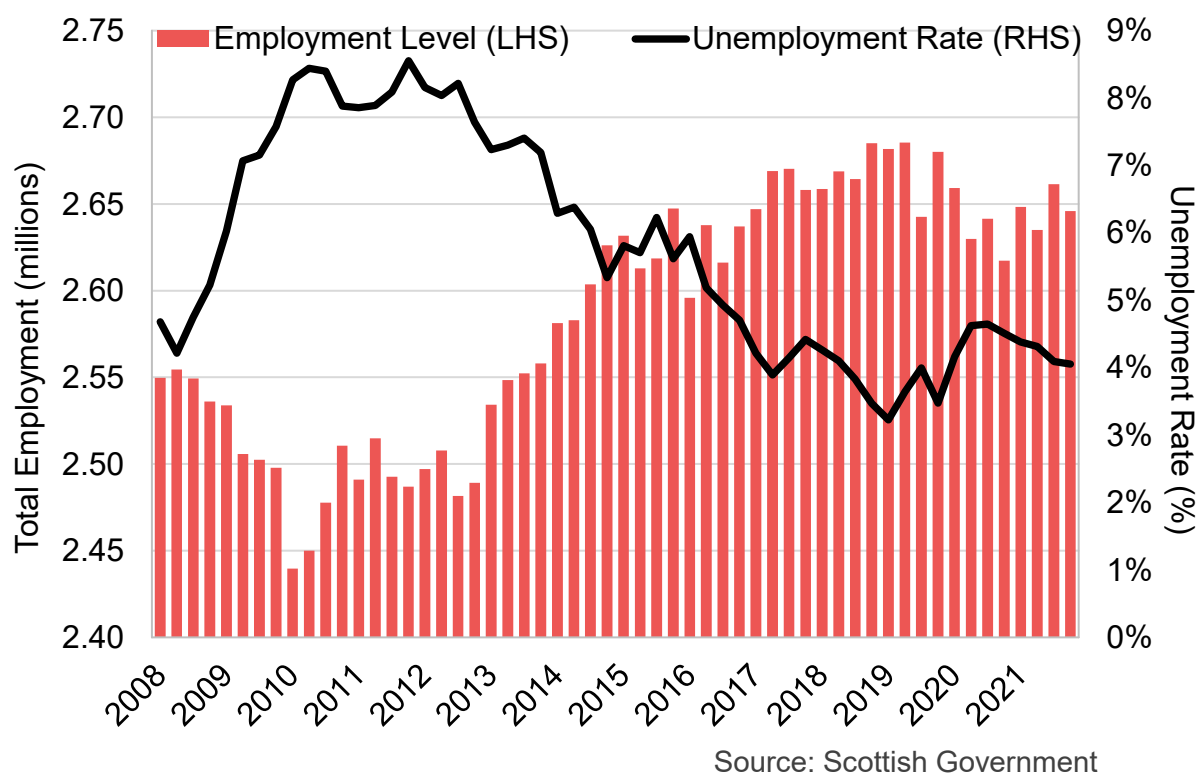


Though a number of sectors continue to face significant challenges as a result of the pandemic, the general economic situation has improved in a number of respects. Overall economic output in Scotland, as measured by Gross Domestic Product (GDP), recently returned to its pre-pandemic level of February 2020 for the first time. Latest monthly data show Scotland's GDP grew 0.8% in November and is 0.6% above its pre-pandemic level. In January 2021, 82% of businesses were trading in some form compared to 98% of businesses in January 2022.

The economic impacts of the pandemic have been felt unevenly across sectors, with those most affected by restrictions being the hardest hit, with the impacts felt by businesses, customers and those whose livelihoods depend on them. Consumer-facing service sectors, such as hospitality, remain notably below pre-pandemic levels. Figure 6 shows that economic output in hospitality in November 2021 was 8.5% below pre-pandemic levels of output and arts, culture and recreation services were 17.9% below. Business resilience remains a key challenge, with data for January 2022 showing that 21.4% of hospitality businesses have less than three months of cash reserves.

Labour market indicators are strong, reflecting the impact of the furlough scheme in protecting jobs to its completion at the end of September 2021. The latest labour market statistics for October to December show that 2.65 million people were employed in Scotland, an employment rate of 74.1% (up 0.8 percentage points over the year), and the unemployment rate was 4.1% (down 0.5 percentage points over the year) (see Figure 7).

Figure 7: Unemployment and employment in Scotland



Notwithstanding the various positive signs for the economy overall, key economic challenges remain, such as the ongoing impacts of BREXIT and broader supply chain issues, staff shortages, pressures on costs for businesses and households, some related to the energy market as well as the cumulative impacts of the pandemic. These impacts are being felt more acutely in particular sectors of the economy and groups in society. Self-isolation rules, particularly during the Omicron wave, added to these challenges.

In the 7 day period to 10th February 2022, visits to workplaces in Edinburgh remain 31% below pre-pandemic levels and those in Glasgow 26% below.¹⁴ The decrease in visits to workplaces as a result of more people working from home has provided benefits over and above reducing infections, with people reporting that they welcome the increased flexibility and reduced commuting costs, and contributed to growth in some local businesses. However, it has negatively affected businesses that rely on office trade, particularly in city centres. And these impacts have not been distributed equally, with certain sectors and professions able to work from home whilst others cannot and have therefore been much more exposed to workplace-related transmission and the threat of workplace closures and lost income.

Effective management of COVID-19 going forwards will strengthen the economy; our forthcoming National Strategy for Economic Transformation will set out how we plan to transform the economy over the next decade.

Throughout this recent, challenging period, schools and other educational institutions were generally able to remain open, though protective measures have remained in place and activities and settings have sometimes been disrupted by the high number of infections. School attendance has generally remained high. Nevertheless, the pandemic has negatively impacted on relationships and development among babies and children, and on concentration and learning in primary school-aged children¹⁵ and has also hampered our efforts to improve school attainment and reduce inequality. In further and higher education, while online learning has allowed for the continuation of many courses, some students have disengaged with online provision, others have been disadvantaged by lack of access to placements and practical training and some have chosen not to take up or have dropped out of courses in greater numbers than before the pandemic. This underlines the need to make education as close to normal as we can in the near future.

More generally, COVID-19 has continued to weigh on us as a society – as it has internationally – affecting our mental health, broader sense of wellbeing, and our ability to make plans for the future.

Throughout the pandemic levels of anxiety and loneliness have been much higher, particularly amongst younger people and disabled people.¹⁶ Managing the risk of exposure to COVID-19, both by adhering to protective measures, and by choosing to

¹⁴ Figures are taken from [Covid-19 Community Mobility Reports](#) published by Google and represent 7-day moving averages to control for daily volatility.

¹⁵ [COVID-19 Early Years Resilience and Impact Survey \(CEYRIS\) - Findings from round three \(September to October 2021\) - COVID-19 Early Years Resilience and Impact Survey \(CEYRIS\) report](#)

¹⁶ Source: [Public attitudes to coronavirus: tracker - data tables - gov.scot \(www.gov.scot\)](#), ONS, [Personal well-being in the UK: April 2019 to March 2020](#)

take other risk-reducing measures has reduced social connection. People have fewer social contacts per day, have reduced participation in sporting, cultural and other activities and whilst there was an increase in informal help and support in the early stages of the pandemic, this has declined over time.

Despite this, one constant positive throughout these difficult times has been the high levels of public support for protective measures in Scotland, and the willingness of people to adhere to them, often at some personal cost. 76% of people in Scotland say they are happy to follow some rules and guidance if it means they can do the things that matter to them, and 75% agree they have a responsibility to follow the rules and guidance from the Scottish Government to keep others safe.¹⁷ This sense of social cohesion and collective responsibility has been central to our management of the pandemic.

Recent polling data show that, as we move ahead into 2022, after two long years of the pandemic, there is an air of increased optimism in Scotland. Around half of people polled say they are sure things will get better soon, compared with only a quarter in the middle of December 2021.¹⁸

COVID-19 will not suddenly go away. However, there are good reasons to hope and expect that in Scotland we are now moving away from tackling COVID-19 as a crisis and towards a calmer phase in which the virus transitions to becoming endemic. It may be liable to periodic surges due to the ongoing risk of new variants - and some short-term measures may be necessary in response - but we should still be able to effectively manage COVID-19 as we do other diseases, with much less recourse to restrictive protective measures than in the past. The next section will set out clearly how we plan to do that.

As we have described, the impacts of COVID-19 are widespread and long-lasting. It will take time to recover, which is why we are focused, alongside managing the ongoing threat of COVID-19, on supporting the recovery and rebuilding for a better future set out in our [COVID-19 Recovery Strategy](#). This Strategic Framework helps to set the solid platform for that broader recovery and later sections of this document will also point to the recovery work taking place at pace across many different fronts.

¹⁷ YouGov survey 18-19 January 2022, data unpublished

¹⁸ Data available at [Public attitudes to coronavirus: tracker - data tables - gov.scot \(www.gov.scot\)](https://www.gov.scot/public-attitudes-to-coronavirus-tracker-data-tables)

Future Strategy

As we have all learned over the last two years, management of the pandemic demands a flexible approach and an ability to respond quickly and decisively. Whilst we may be beyond the peak of the latest Omicron variant, we know that there is a continuing COVID-19 risk to manage in the future. There is no absolute certainty in what lies ahead, but by carefully monitoring the situation and having in place effective contingency plans, we can reduce risk and harm in more proportionate and less restrictive ways.

Over the period from initial lockdown in March 2020 through to spring 2021, when the risk of infection was high and before the positive impact of vaccination and more effective treatments were available, our response was characterised by extensive (though variable) use of legal restrictions and requirements. Individuals and organisations also adapted their behaviours and physical environments to reduce transmission risk.

Since summer 2021, the use of protective measures, both regulations and guidance, has remained important – particularly to deal with the Omicron wave – but has been much more targeted, as the positive impact of the vaccination programme has helped reduce serious health harm.

Looking forward, we expect to be able to rely much more on the beneficial impact of immunity, on the increasing availability of effective treatments, and on routine adaptations to behaviours and environments, to render the use of legal measures at best unnecessary and at worst limited and temporary.

But we must also acknowledge the risks we face – of new, more harmful variants appearing or of waning immunity. In addition, seasonal factors may shape people's behaviours and increase transmission. Each of these – and in particular a combination of them – might cause a period of increased harm from the virus and require us to consider whether, when and to what extent a temporary increase in protective measures was necessary and proportionate. We expect that, often, no additional intervention will be required but we need to be ready to respond if and when it is.

Strategic Intent

We must maintain and improve our strategies to sustain immunity, enhance the availability of and access to treatments, adapt behaviours and physical environments, monitor risk from the virus, and develop contingency plans, all with the aims of reducing both the risk of infection and harm from the virus. This Strategic Framework sets out the various elements of that work in the sections below, within the overall context of our strategic intent.

In light of the current state of the epidemic and our consideration of future potential scenarios, we judge that the strategic intent guiding our COVID-19 response should be changed to reflect the calmer phase of the pandemic that we are hopefully now in, and the possibility of the virus becoming endemic:

To manage COVID-19 effectively, primarily through adaptations and health measures that strengthen our resilience and recovery, as we rebuild for a better future.

Practically, this means that we expect to be less focused on suppressing case numbers than in the past, and more on reducing and mitigating harm. This recognises that - after two years of the pandemic and in light of vaccines and treatments - the impact of the other harms that arise from a strategy overly focused on suppression is too great.

Whilst it is inevitable that a varying level of COVID-19 will continue to circulate in society, our new strategic intent does not signal a willingness to allow the virus a free hand regardless of the harm it might cause. Instead, it will help to ensure that our overall approach and any future use of protective measures – should we face a significant new threat – is necessary, proportionate and consistent with our broader purpose of creating a more successful, sustainable and inclusive Scotland.

The revised strategic intent recognises that responsibility for the management of COVID-19 is shared by central and local government, wider public services, businesses, the third sector, communities and individuals. While central government will always have a responsibility to lead, support and, if necessary, take tough decisions, we all have a part to play in remaining vigilant for COVID-19 infections, in adapting how we live, work and interact to reduce harm, and for building greater resilience against potential acute phases of the virus in the future.

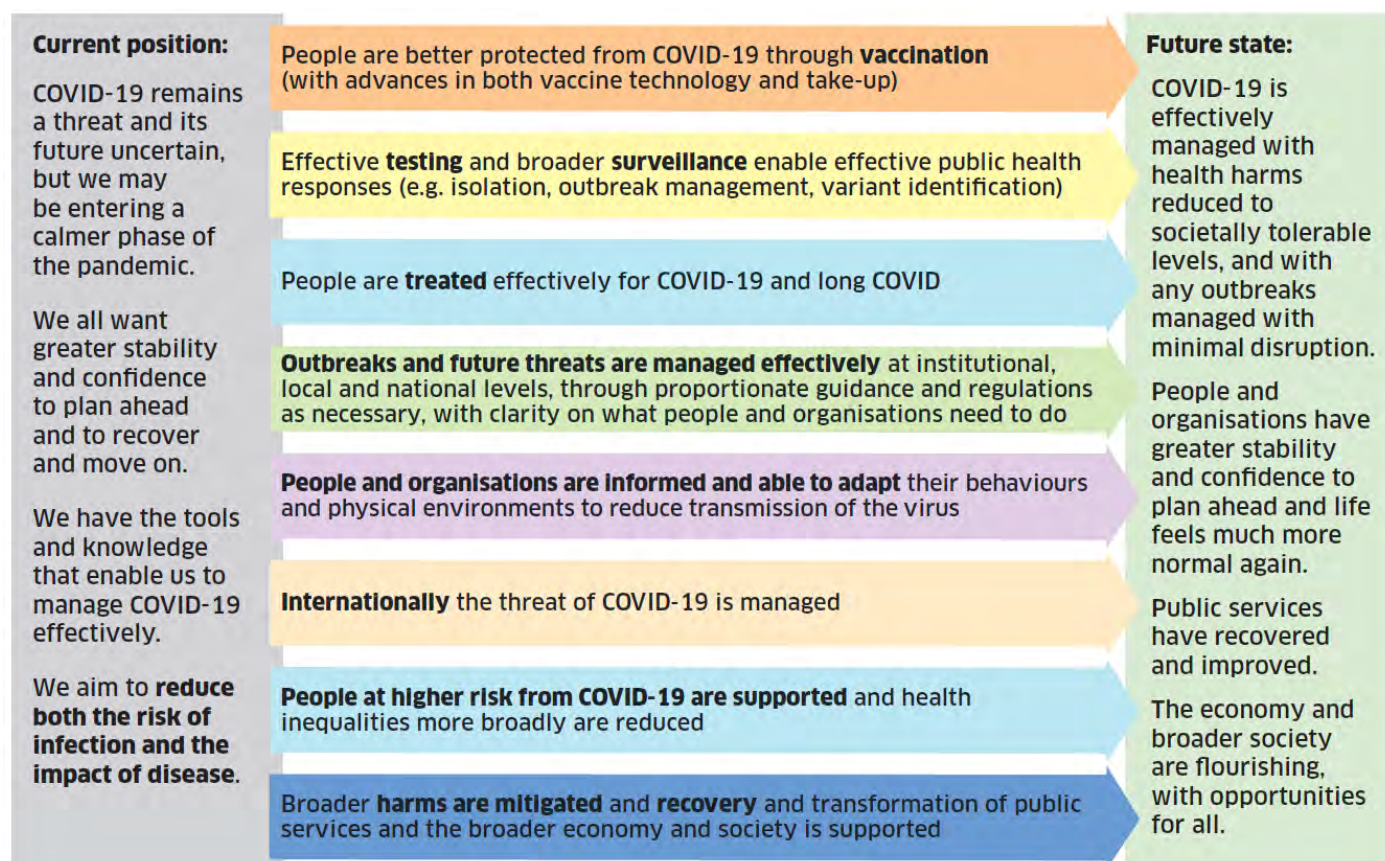
Delivering this strategic intent will require a range of actions across a number of areas as summarised below and set out in further detail in later sections of this document. These include: health measures such as vaccination, treatment, testing, surveillance, and strengthening the resilience of health and social care generally; adaptations to behaviours and physical environments to reduce the spread of the virus; and the ability to monitor and respond effectively to renewed threats, including more harmful variants of the virus. If we can collectively deliver on these actions then the prospect of both managing COVID-19 effectively and restoring and retaining normality in our lives is achievable.

Health

Health measures - such as vaccination - that strengthen our resilience will continue to be a vital aspect of our approach to managing COVID-19 effectively. We will use expert scientific and clinical advice and our well established infrastructure to build on our learning throughout the current vaccination programme. The success of the programme to date has been remarkable, both in scale and impact, and it will continue to develop as we help ensure that everyone who will benefit from a vaccination is able to receive one, including further booster shots if recommended, and as we integrate future advances in vaccine technology into our programme in line with future JCVI advice.

We will also continue to invest in our public health capacity and capabilities to support greater resilience in the health and social care system.

Figure 8: COVID-19 Response Strategy



Monitoring disease prevalence through appropriate testing and wastewater sampling must continue, and we need to retain and enhance the capability to track new variants through PCR testing and genomic sequencing. We will continue to maintain and develop a proportionate testing capability, to support public health decision-making, population health, and treatment of those who will benefit from it. Adequate surveillance, internationally and domestically, is critical.

For those who become infected and subsequently require treatment, there is now a range of therapeutics that can lower the risk of serious illness or death. We will continue to develop new and better approaches, and invest further in treatment and vaccine clinical trials, especially for those who are most at risk of severe disease. We will also broaden our understanding of the long-term effects of infection, particularly the syndromes known as Long COVID, so that we can continue to improve treatments and outcomes.

Adaptation

We must build a stronger, infection-resilient society and there will be an ongoing ask of the public and organisations to take responsibility for their safety. This includes embedding many of the protective behaviours we have become so familiar with over the past two years into our daily lives and business operations. We will ensure that clear and up-to-date guidance and information is available to help achieve and maintain safer behaviours.

In terms of adapting where and how we work, live and access services, it will be essential for us to work together to make buildings and settings safer, for example through better ventilation, and in so doing limit transmission. As part of this, we will continue to encourage employers to engage with employees to consider, for the longer term, hybrid working models where feasible and appropriate. We recognise the broader impacts of hybrid working and will continue to work with partners to learn from best practice.

Effectively responding to future threats

We expect there to be future outbreaks or resurgences of the virus: these will occur at an institutional, local or national level. Guidance on the Management of Public Health Incidents will be updated, and we will develop with partners a new framework of modelling, data and analysis to support the future monitoring and surveillance of COVID-19. This will help us determine when and how we need to respond.

At a national level we will implement measures that are necessary and proportionate to the threat posed by the virus. We hope that a very small number of ongoing protective measures will keep the harm from the virus in check in the near term and provide the longer term stability that we need to plan ahead.

We expect that there might be occasional, acute periods over the next few years when it will be necessary to increase protective measures temporarily, for example, to control a harmful new variant of the virus. We will be prepared for that and want to provide as much clarity in advance as possible (as set out in the Protective Measures section below). However, we will do this only when absolutely necessary and in as limited and targeted a way as possible. It is important to stress that we are at a point now where life can be expected to be much more normal for much of the time.

To inform the response to an outbreak of a potentially dangerous variant of COVID-19, the Scottish Government with Public Health Scotland (PHS), Local Government and other partners, are developing the COVID-19 Outbreak Management Plan, which will set out the process and methods for responding to future outbreaks. We aim to publish this in spring 2022.

The variant outbreak responses described in the COVID-19 Outbreak Management Plan will be designed to operate as a set of short and medium-term measures that can mitigate impact across the country or in specific localities. It will include processes to: commission and use evidence, data and risk analysis from both PHS and UKHSA; assess the risk posed by a variant; determine possible response objectives and options; and continually assess the operational impact throughout any period of intervention.

Adequate surveillance, both internationally and domestically, at borders and across the population is critical to provide advance warning of potentially dangerous variants. That is why the COVID-19 Outbreak Management Plan will be supported by the use of existing and new and emerging testing and surveillance procedures to support early identification of future variants, including whole genome sequencing, wastewater surveillance, testing and contact tracing.

Legislation

In order to maintain the ability to respond effectively to the future threats that the virus may pose – within institutions, locally or nationally – we will ensure that necessary legislation is kept up-to-date. Having this legislation in place does not, of course, mean that it will be deployed – but it does mean that it will be ready should it be required. And whenever legal measures are deployed, they will remain subject to ongoing regular reviews of necessity and proportionality to ensure that they are removed as soon as no longer required. Existing coronavirus legislation is expiring this year and Scottish Ministers propose that it be replaced with provisions in the [Coronavirus \(Recovery and Reform\) \(Scotland\) Bill](#) which was introduced to Parliament on 25 January 2022. This non-emergency legislation is intended to support our [COVID-19 Recovery Strategy](#) and embed any of the COVID-related measures that have delivered improvements for people using public services.

International Context

As we think about the next phase of our response to COVID-19 and fix our sights on recovery, we also recognise that COVID-19 is still affecting different parts of the world in varying degrees and that the pandemic will not be over until it is effectively managed internationally. That highlights the need to continue with efforts to support international vaccination, treatments and surveillance.

Equality and inclusion

We must continue to consider the needs of everyone in society in developing future adaptations, mitigations and protective measures. The pandemic has exacerbated inequalities, poverty and disadvantage, and there is clear evidence that harm has been felt unevenly, including by people and communities who were already experiencing poorer outcomes. Disabled people, minority ethnic communities, people on low incomes, older people, younger people, and women are amongst those who have experienced greater impacts, with multiple disadvantage making things even harder for many. It is imperative that we continue to ensure that any continuing or new measures do not exacerbate inequality, which is why equality, human rights and inclusion remain at the heart of our ongoing response. We need to ensure that everyone can live their lives with greater normality as we open up society and learn to live with COVID-19. We cannot let it become established as a disease of the poor, disadvantaged or clinically high risk.

Future pandemics

Plans, procedures and protocols to help Scotland prepare for infectious threats, such as an influenza pandemic, are in place, alongside the legislative mechanisms that underpin how infectious hazards are managed when they occur in Scotland. That legislation is being strengthened through the Coronavirus (Recovery and Reform) (Scotland) Bill to ensure that Scotland is in the best possible position to protect the health of its citizens from an infectious threat. PHS provide strategic leadership in guiding and supporting our response to high consequence infectious diseases.

The last two years have seen huge investment globally and within Scotland in surveillance, testing, vaccination and therapeutics, alongside our understanding of what measures make people safer. The body of scientific and clinical knowledge about COVID-19 has hugely increased, as has public awareness. In all cases, the science and research that has supported our efforts, and keeps us safer, depends on national and international co-operation.

As new variants of SARS-CoV-2 emerge, we now have the capability to generate much of the data and analysis we need within Public Health Scotland and the Scottish Government. Alongside that, our scientific and research communities are active nationally and internationally and have benefited from the advice of the Scottish Government's COVID-19 Advisory Group.

Existing public health knowledge must absorb and adapt to the new technologies that have changed our ability to detect, understand and respond to new viruses on a different scale. While our ability to respond to new threats has advanced, we must accept that the rate at which we will face them has also increased. Ecological and technological changes mean the chances of new viruses emerging have increased, and global travel patterns mean they are more likely to spread when they do. To capitalise on this investment and learn from the experiences of the pandemic we will:

- commission the Standing Committee on Pandemics to provide a report to us on improved preparedness for future pandemics, with interim recommendations by July 2022;
- use that report, and in due course, the outcomes of the Public Inquiry to inform our approach to surveillance, monitoring, diagnostics, vaccination and treatments;
- work under the Common Framework on Public Health Protection and Health Security to strengthen coordination of public health and health security policies; and
- work across the four nations of the UK, and with the UKHSA and other international organisations to promote measures that increase biosecurity.

Next Steps

We hope now to be entering a calmer phase of the epidemic. That allows us to consider afresh the adaptations that we need to make to build our resilience and manage the virus in a less restrictive way going forwards, helping Scotland recover and rebuild for a better future.

The continuing loss of life to COVID-19, the continuing suffering of those with Long COVID, and the challenges that many businesses, organisations, families and individuals continue to face as a result of the pandemic remind us of both the continued seriousness of this virus and the need to learn lessons for the future, which the coming COVID-19 Public Inquiry will help us to do.

The various interventions that we are taking and will take in the future to tackle the epidemic are set out in the elements of our Strategic Framework below, which have been updated to reflect our new strategic intent.

Delivering our approach

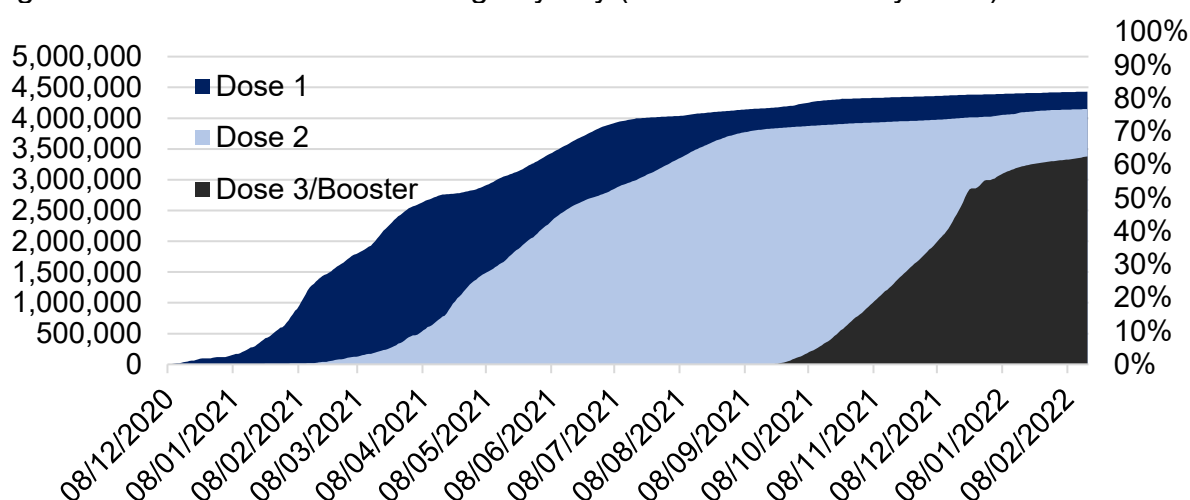
Vaccination

Progress

Vaccination remains a critical component in our response to COVID-19. From the outset the primary objective of the vaccination programme has been to prevent severe illness and death associated with the virus. Our vaccination programme has delivered on this, with the [WHO](#) reporting that up to November 2021, vaccination in Scotland was likely to have prevented over 27,000 deaths from COVID-19. Recent evidence has also highlighted the important role boosters can play as part of our ongoing response, especially to emerging variants such as Omicron.

Scotland's autumn/winter Flu and COVID-19 Booster Programme which began on 6 September 2021, has now surpassed 6.7 million doses and builds on the 7.8 million COVID-19 vaccinations delivered during the first phase of the Programme (between December 2020 and September 2021). As of 21 February 2022, there had been over 11.9 million COVID-19 vaccine doses administered in Scotland, and over 2.7 million flu doses.

Figure 9: Total vaccination coverage by day (data to 18 February 2022)^{19 20}



In order to protect more people in Scotland, and in line with the independent and expert advice received from the Joint Committee on Vaccination and Immunisation (JCVI), we have expanded our COVID-19 vaccination eligibility criteria. More individuals under the age of 18 are now eligible for first and second doses, with some also eligible for boosters. All adults (16 and over) are eligible for a booster vaccination and, third primary doses are now being provided for all those aged 5 years and over, who at the time of their first or second dose are identified as being severely immunosuppressed. Following receipt of JCVI advice, we are also starting to offer vaccines to all 5 to 11 year olds recognising that this will offer protection from serious illness and hospitalisation in a future outbreak.

¹⁹ Data available at, [Public Health Scotland Covid-19 dashboard](#)

²⁰ From 11 November 2021, 'booster & dose 3' are combined under one number. Until then, the numbers reported were for booster vaccine.

As of 18 February 2022, 92% of those aged 12 years and over have had a first vaccine dose and 87% have had a second dose. In addition, 84% of 16 to 17-year-olds had received a first dose of the vaccine with 58% also receiving their second dose. Currently over 3.3 million booster/third doses have been delivered which equates to around 71% of the eligible 12 and over population.

Next Steps

We are now working on the delivery plan to offer vaccination to all 5 to 11 year olds, following recent advice from the JCVI and will be shortly offering an additional booster to all adults over 75 years old, care home residents and everyone over 12 who is immunosuppressed.

We also have a planning assumption that there will be a continued need for vaccinations in response to COVID-19 in 2022/23 and beyond. We are, therefore, preparing for a continued need for some level of ongoing booster vaccination activity, particularly for those at highest risk.

We are also ensuring that people who may experience barriers, or feel less confident, are able to come forward for vaccination. We are increasing our efforts to ensure the vaccination programme reaches everyone and is fully inclusive with a range of outreach activities and partnerships with community and third sector organisations to engage with under-represented groups. This will include the continued use of research and focus groups to understand the reasons and potential barriers to individuals who may be vaccine hesitant. Building on our approach used for under-represented groups, this will inform our communications and engagement activity, and also our deployment model.

Current evidence provides confidence that the booster vaccination programme has greatly strengthened population immunity against severe illness. However, we also know that evidence is still emerging on waning vaccine protection, and there is a risk of future Variants of Concern developing - against which protection afforded by vaccines may differ.

On that basis, we are planning for a number of different scenarios including an annual booster programme, for those who are at risk and possibly more frequently for the most clinically vulnerable. These planning assumptions will be refined once we receive further JCVI advice on this issue. We are aware of the need to deliver rapidly in response to either a new variant and/or the emergence of a more variant-specific vaccine. Work is in hand to develop surge plans that could be rapidly deployed, if required, building on the lessons learnt from our response to Omicron in November and December 2021.

A core element of activity and planning is to ensure that there is a sustainable model for the delivery of COVID-19 vaccines alongside existing vaccination and immunisation programmes in Scotland. COVID-19 learning and infrastructure provides us with an opportunity to consider the full range of immunisation activity to achieve a positive and lasting legacy from the pandemic. We are therefore taking into consideration the Scottish Vaccination and Immunisation Programme (SVIP) aspirations and ensuring that existing vaccination programmes are maintained as part of our overall public health objectives.

Testing and Surveillance

Progress

The Test and Protect programme has continued to play a key role in our response to COVID-19 by providing testing, contact tracing and supporting self-isolation, all essential in reducing the health and broader harms caused by COVID-19.

The advent of Omicron tested the system to its maximum levels, with record-breaking levels of PCR testing conducted, LFDs distributed and results reported by the public. Winter saw the highest ever levels of PCR testing for COVID-19 since the pandemic began. The period of significant testing demand meant that the volumes of PCR test results being reported in the first week in January 2022 (452,000 tests) was double the level that was reported in the first week in November 2021 (226,000 tests).

In response to the unprecedented increase in demand, in December sampling capacity was maximised by increasing booking capacity by 50% at test sites, along with increased laboratory, PCR home test and online LFD ordering capacity. When the testing system demand reached 85% capacity levels (on 29 December) we started prioritising access to PCR test sites for essential workers, highest risk groups and those eligible for new COVID-19 treatments.

Since the festive period, and changes to testing policy to remove confirmatory PCR tests, we have seen a significant decrease in the levels of daily PCR testing, now settling at around 8,000-12,000 tests per day.

The high number of cases driven by Omicron, and our guidance and intensive media and marketing activity to encourage people to use LFD tests before mixing with others over the festive period, also saw exceptional demand for LFDs over December and early January. Demand reached as high as 8-10 million tests each week, compared to the 10 million LFD tests distributed per month in the autumn. The increase in demand for tests also led to a significant increase in the number of LFD results being reported, with the numbers of tests per week being recorded increasing by 135% between the end of November and the end of December. Record numbers of individuals also entered the contact tracing system over this period, with over 130,000 unique positive cases being created in the contact tracing system within one week at the turn of the year - compared with around 20,000 index cases per week in late November 2021. The number of LFD results reported has been decreasing in the early weeks of 2022 but the levels of LFD test result recorded in the week ending 13 February 2022 remained over 94% higher than at the end of November 2021.²¹

In response to the emergence of the Omicron variant, public health advice on self-isolation changed in December to reflect the early evidence on transmissibility and the lack of data, at that point in time, on the potential severity of Omicron and consequent population health risks. As evidence accumulated, and the vaccination booster programme rolled out, from January 2022, further policy changes included:

²¹ [Dashboard - COVID-19 statistical report - 16 February 2022 Public Health Scotland](#)

- reducing the isolation period for index cases from 10 to 7 days to improve workforce and system resilience across key sectors of the economy;
- removing the requirement for a confirmatory PCR after a positive LFD;
- replacing negative PCR with negative LFD to release from isolation; and
- removing the close contact isolation requirement for triple-vaccinated adults/under 18s with negative PCR/LFD.

Next Steps

Our approach to testing – and to tracing and isolation – has continually adapted as pandemic conditions have changed; as our understanding of the virus and disease has grown; as new technologies have become available and their reliability has been demonstrated; and as the public have adopted new behaviours and understanding of testing as a means of reducing risk. This adaptation will continue, and the scale and place of Test and Protect in our range of interventions will adapt to be proportionate to the requirements of future phases and in alignment with our updated strategic intent.

As part of a careful and phased transition – the detail of which we will set out in March - our Test and Protect approach will focus on the following key priorities:

- to protect the most vulnerable and those at highest clinical risk (a core priority throughout the pandemic);
- to support patient care;
- to monitor disease prevalence;
- to respond to outbreaks; and
- to scale as required for future health threats.

As we move through the spring and into the summer, our priorities will move away from the current routine asymptomatic programmes of testing towards ensuring continuing and sufficiently rapid access to:

- testing for those who require clinical care or would benefit from new and emerging treatments;
- a continued focus on protecting those at highest clinical risk;
- maintaining sufficiently robust surveillance (including genomic sequencing) to detect emerging issues early enough for effective response;
- continuing to support local responses in communities where there is enduring transmission; and
- supporting outbreak management and mitigation in particularly high-risk settings – with the ability to scale our response as required to address threat levels in the future.

In order to move to this new Test and Protect approach we are developing a managed transition plan which will ensure that Scotland continues to have a proportionate and effective testing response and effective domestic and international surveillance infrastructure.

We will publish a detailed transition plan in March setting out updated plans for Test and Protect for the endemic phase, and how we will manage the transition from the

current position to that end steady state. This will confirm the duration of the transition beyond the end of March. It will also include detail on surveillance capabilities that will remain long term; contingency infrastructure scalable if required in the event of a future variant; and continuing provision of testing to protect those most vulnerable, support clinical care, enable prompt treatment for COVID-19 patients where required, and build a legacy for wider population health benefit.

In the meantime, we will continue to support access to PCR and Lateral Flow Testing on the same basis for the general population as now, subject to the changes in advice on frequency of lateral flow testing set out below.

In line with our progress through the Omicron wave, we are evolving our population level asymptomatic testing approach from the current advice to test on every occasion before mixing with others, back to advice to test at least twice weekly and in particular before mixing in crowded places or with anyone who is clinically vulnerable through age or other health conditions.

We are also reviewing the frequency of asymptomatic testing taking place within our health and social care workforces and may revert in the period ahead from daily to twice weekly testing. However we will only do this in line with the latest clinical advice and risk assessments.

We have also asked the educational advisory subgroup for advice on lateral flow testing for schools and will update our approach when this is available.

We still advise those with symptoms to book a PCR test.

And we continue to advise anyone who tests positive – either through a PCR or a Lateral Flow Test – to stay at home for the recommended period of isolation to reduce the risk of infecting others, including those who may be clinically vulnerable. We will keep the recommended period of isolation for positive cases under review. Contact tracing and advice to contacts also continues at this point, as does support for those advised to isolate.

At the conclusion of the transition period, contact tracing and isolation are likely to focus more on those settings that are highest risk, with local Health Protection teams empowered to make local public health decisions on how to reduce risks to people who are clinically vulnerable. Subject to ongoing evidence of vaccine efficacy, population wide isolation guidance will focus on encouraging people with symptoms of respiratory illness to remain at home whilst unwell.

Our detailed transition plan will be published in March setting out updated plans for Test and Protect for the endemic phase, and how we will manage the transition from the current position to that end steady state. This will include detail on surveillance capabilities that will remain long term; contingency infrastructure scalable if required in the event of a future variant; and continuing provision of testing to protect those most vulnerable, support clinical care, enable prompt treatment for COVID-19 patients where required, and build a legacy for wider population health benefit.

COVID-19 Surveillance

Alongside the test and protect system, the Scottish Government has worked with PHS and the UK Health Security Agency (UKHSA) to undertake a number of enhanced public health surveillance programmes that provide deeper insight into the impact of COVID-19 on people living in Scotland and on NHS services in Scotland. These programmes provide statistically and clinically robust information on transmission, on immunity and on the effectiveness of clinical and public health countermeasures, which has supported public health decision making.

In addition, since September 2020, people living in Scotland have participated in the UK-wide ONS COVID-19 Infection Survey, which is partly funded by the Scottish Government by forgoing Barnett consequentials. This survey provides vital data that inform weekly estimates of the number of people living in Scotland who are positive with COVID-19, and fortnightly estimates of the number of people testing positive for antibodies from a blood sample. This method has allowed a stable platform for assessment of incidence and prevalence unaffected by changing population use of PCR or LFDs, which has been problematic for other surveillance components.

Through a collaborative programme of work with the Scottish Environment Protection Agency (SEPA), Scottish Water and bioinformaticians, we are collecting data through wastewater surveillance to inform weekly [modelling the epidemic reports](#).

The continuing pandemic, and the potential for the resurgence and atypical circulation of other respiratory pathogens, underlines the need to enhance existing epidemiological surveillance systems in order that we respond early, proportionately and precisely. Over the next year, we will continue to work with stakeholders to ensure an appropriate surveillance system is in place to monitor, track and respond to future changes in the pandemic and the effectiveness of our interventions.

This system will include developing an enhanced community surveillance in primary and secondary care, early detection of new variants through Whole Genomic Sequencing (WGS) in collaboration with UKHSA and international partners, understanding the opportunities presented through waste water surveillance and exploring future joint opportunities with other UK nations. Details of the surveillance programme will be included in the updated Test and Protect plan.

Self-isolation support

While self-isolation advice remains a population-wide intervention, support for people self-isolating will continue including the Self-Isolation Support Grant. As isolation guidance evolves, we will continue to consider where targeted isolation support, including financial support, is required to support communities experiencing enduring transmission and COVID-19 related health inequalities.

Data and Analysis

Scottish Government decision-making throughout the pandemic has been based on a range of evidence including scientific and clinical studies, modelling, behavioural research, statistics and analysis. Much of this has necessarily been new and we

worked with partners, including PHS and UKHSA, to rapidly develop new data collections and reporting over the course of the pandemic.

This has included rapid data and intelligence to support and inform decision-making such as case numbers, hospital and ICU occupancy, deaths, vaccinations, and other COVID-related data covering schools, care homes and NHS absences. Key published data series have included reporting of headline daily data on the Scottish Government Coronavirus web pages, a weekly [State of the Epidemic](#) paper and the latest ONS COVID-19 Infection Survey results. PHS have also developed significant new and interactive reporting on the PHS COVID-19 Daily Dashboard and Education Surveillance Dashboard and continued to develop the content of its PHS weekly COVID-19 statistical report that is published every Wednesday.

We now need to consider what evidence, data and analysis will be required going forward. Work is now under way with PHS and our partners to review the content and frequency of all of our current reporting to identify what is required to support resilience and recovery in the future. This will involve prioritising the modelling, data and analysis that is essential to support the future monitoring and surveillance of COVID-19. We are now identifying the key public reporting that needs to be retained and the frequency of publication. We will publish a data and reporting strategy in spring 2022 to support implementation of the Strategic Framework. We will ensure that users and the public are consulted on any planned changes to public reporting.

Treatment

Thanks to advances in health research, treatments are becoming an increasingly important part of our overall approach to managing COVID-19 for the long term. This section sets out both what we are doing to ensure that people are able to receive effective treatment for COVID-19, drawing on advances in technology and practice, and our activity to support people affected by the long-term effects of COVID-19.

COVID-19

Progress

A range of new therapeutics is now well established in the management of patients who have been admitted to hospital with COVID-19. Treatments including dexamethasone, neutralising monoclonal antibodies, remdesivir, tocilizumab and sarilumab can reduce serious illness and deaths.

We are now also offering new therapeutics which have been authorised by the Medicines and Healthcare products Regulatory Agency (MHRA) for use in non-hospitalised patients at higher risk of admission from COVID-19.

Since 22 December 2021, adults and children (aged 12 years and above) are eligible to be assessed for their suitability for new COVID-19 treatments if they meet certain eligibility criteria. The list of clinical conditions prioritised for treatment was developed by an independent UK expert working group based on detailed clinical evidence and is designed to support targeting those higher-risk patients who have the potential to both be at highest risk of disease progression, hospitalisation and death and be least likely to generate a material immune response to vaccine. More information on the eligibility criteria and access arrangements can be found on [NHS Inform](https://www.nhsinform.scot/covid19treatments) (<https://www.nhsinform.scot/covid19treatments>).

In addition to the direct access arrangements described, oral antiviral treatments for COVID-19 are being evaluated through a UK-wide study called PANORAMIC, run by the University of Oxford. This is open to people living anywhere in the UK who meet all three of the following criteria:

1. a positive PCR test result for coronavirus;
2. feel unwell with symptoms of coronavirus that started in the last five days; and
3. are aged 50 or over or aged 18 to 49 with an underlying medical condition (full details at <https://www.panoramictrial.org/>) that can increase the chance of having severe coronavirus symptoms.

Next Steps

The national study will lead to the collection of additional data to enable the NHS to fully understand how best to make use of these antiviral treatments in the future.

Long-term effects of COVID-19 (Long COVID)

Progress

NHS Scotland continues to deliver a range of services to support the individual needs of people affected by the long-term effects of COVID-19.

We are implementing the 16 commitments to improve care and support for people with long COVID-19 contained in our approach paper [Scotland's Long COVID Service](#), which are backed by a £10 million Long COVID Support Fund. Our approach is based on maximising and improving co-ordination of the broad range of existing services across our health and social care system and third sector that are relevant to the spectrum of symptoms that people are experiencing.

In addition, we have developed a long COVID information platform on [NHS inform](#) to help people manage their symptoms and access further support where required.

This initiative was supported by a targeted marketing campaign which ran through October and November 2021 with information displayed in GP surgeries and community pharmacies. A campaign toolkit was also sent to 250 direct partner contacts with additional distribution to approximately 3,000 contacts.

Next Steps

We will continue to support the implementation of the UK-wide [clinical guideline on the long-term effects of COVID-19](#), developed by the Scottish Intercollegiate Guidelines Network (SIGN), the National Institute for Health and Care Excellence (NICE) and the Royal College of General Practitioners (RCGP), through which clinicians can access evidence-based information and advice to inform assessments, investigations and referrals for their patients.

NHS National Services Division is establishing a Strategic Network bringing together clinical experts, NHS Boards and lived experience to support the ongoing development, resourcing and implementation of services for people with long COVID in Scotland.

Deploying Protective Measures When Necessary

As the updated strategic intent makes clear, in the future we expect health measures and adaptations to be our primary means of managing COVID-19 effectively, enabling a sustainable return to much more normality.

However, there remains a need for protective measures as a contingency that can be deployed if and when the virus again threatens us with excessive harm, which we hope will rarely be the case. By 'protective measures' we mean legal requirements (regulations) and targeted guidance over and above more general positive behaviours, adaptations and good practice measures to curb the virus.

Protective measures would be used temporarily to respond effectively to increased threat from the virus, for example, if a more harmful variant was identified. We want to provide as much clarity around this as we can, notwithstanding the uncertainty inherent in the virus, to help people and organisations plan for the future.

Current measures

Thanks to the collective efforts of the people of Scotland and the success of the booster rollout, we currently have relatively few protective measures in place to help manage COVID-19. Nevertheless, the virus continues to cause significant harm to our health, essential services, economy and society. Many of those who are at higher clinical risk are still wary of undertaking normal everyday activities and we are seeing the ongoing impacts of long COVID on previously healthy individuals. Our NHS and social care services continue to face a challenging period ahead as they deal with the backlog of patients as well as ongoing COVID-19 hospitalisations.

So we must all continue to exercise caution and be vigilant. We continue to encourage everyone to:

- Increase ventilation by opening a window, or going outdoors.
- Wash your hands and cover your nose and mouth if coughing or sneezing.
- Where appropriate, do a mixture of home and office ('hybrid') working.
- Get your vaccine or booster when you are eligible.
- Use the [Protect Scotland](#) and [Check-in Scotland](#) apps.
- Take a Lateral Flow Device (LFD) twice weekly, in particular before mixing in crowded places or with anyone who is clinically vulnerable;
- Take a PCR test if you develop COVID-19 symptoms or if Test and Protect ask you to.
- Self-isolate for the recommended period if you test positive or are asked to do so by Test and Protect.

While most of the regulations regarding protective measures have now been lifted there are still four baseline measures that continue to be required by law (at the time of the publication of this document):

- You must wear a face-covering in most indoor public spaces and on public transport (unless an exemption applies).
- Hospitality businesses are required to collect and share customer information to support Test and Protect contact tracing.
- Businesses, service providers and places of worship are required to have regard to guidance about reducing risk of exposure to COVID-19 on their premises and take reasonably practicable measures to reduce incidence and spread of COVID-19 on their premises.
- Large events and late night venues must operate the COVID-19 certification scheme. [See below for plans to adjust this measure.]

In time we plan to convert these legal measures to guidance, and often it will make sense for individuals and organisations to continue to adopt them, where appropriate, in order to help maintain effective control of the virus. It will remain important to consider how the decisions we all make can affect others, particularly those who may be at higher clinical risk from COVID-19.

Figure 10: Planned conversion of regulations to guidance and routine behaviours

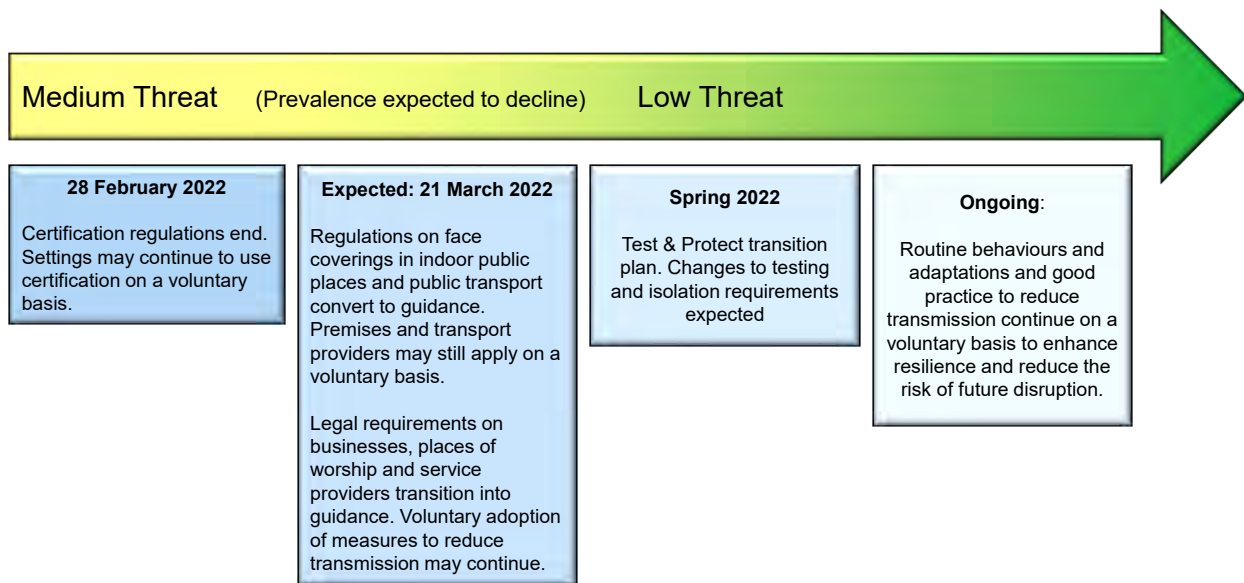


Figure 10 sets out our plans for moving the remaining protective measures from regulation to guidance and good practice.

On 28 February, the legal requirement for COVID-19 certification in certain settings will end. Some premises may, however, wish to continue to require such certification, to make their customers and staff feel safer.

On 21 March (*indicative date, to be confirmed at preceding review*), we plan to remove the legal requirement for face-coverings in indoor public places and on public transport. Again, some settings and service providers may wish to maintain face-covering policies to help to protect their customers and staff. Other remaining legal requirements will convert to guidance and good practice as appropriate.

Following this, we plan to move to a more sustainable approach to testing, self-isolation and contact tracing, as we progress through our Test and Protect transition plan. We will provide more information about the future requirements closer to the time.

We anticipate moving to a position where, as with other infectious diseases, we advise people generally to stay at home if they are unwell until their symptoms resolve and they feel better. This will continue to help protect others, and will be of particular benefit to those who may be at higher clinical risk. Testing is likely to remain an element of our management of the virus in particular settings, for example to help protect those at higher clinical risk, and to maintain surveillance of the virus and its variants.

Once legal requirements are lifted, we expect that people and organisations will continue as a routine to adapt their behaviours and settings in ways that reduce the spread of the virus. This will help us all to enjoy as much normality as possible and provide resilience to future threats from the virus, potentially reducing the need for increasing protective measures again.

Responding to future threats

Despite this planned shift away from legal requirements, we will still need to manage COVID-19 effectively because the virus remains a threat. We are likely to continue to see outbreaks in Scotland over the coming years, and can expect new variants to appear globally. We should expect a degree of ongoing uncertainty about the threat posed by the virus. If infections rose too high or the impact of the disease became too grave, then the harm in terms of mortality and morbidity, including long COVID, would be excessive and our NHS would again be at risk of being overwhelmed. It may therefore prove necessary to take steps to protect people from serious illness and death. This might involve implementing temporary and targeted protective measures, either within individual settings, in certain localities or nationally.

Local Outbreak Management

Working collaboratively with public health and local government partners, we are developing and will publish a COVID-19 Outbreak Management Plan. This will set out a set of short and medium-term measures that can mitigate impact in specific localities. It will include processes to commission and use research, to assess the risk posed by a variant, determine possible response objectives and options and continually assess the operational success through intervention.

The guidance on the Management of Public Health Incidents sets out the strategic approach to managing public health incidents (including outbreaks of infectious diseases) and provides support to NHS Boards in preparing for and responding to incidents, allowing flexibility to respond as appropriate in collaboration with partners.

We will use the collective learning of the last two years to consider with PHS, Directors of Public Health and partners from local government and other agencies any changes that may be required to the guidance on the Management of Public Health Incidents.

Managing future threats at the national level

Through adaptations to our behaviours and physical environments to reduce the spread of COVID, and through effective vaccination and treatment, we can reduce the risk that we will need to escalate protective measures in the future. The better we collectively do at protecting ourselves through making these measures routine, the less the future need for additional measures in the event that a more harmful variant arises as it should cause less harm.²² This is because adaptations help to reduce infection risk, treatments help to reduce disease impact, and vaccinations help to reduce both.

Though these routine efforts will reduce the impact of a more harmful variant, there remains the risk that a new variant will arrive in Scotland that is sufficiently harmful, in terms of transmissibility or severity (or both), that it requires additional protective measures, for a temporary period.

We will remain vigilant for this risk, through ongoing surveillance of the evolution and spread of variants. Vigilance and preparedness are important because there are times when responding quickly can mitigate harm and potentially avoid the need for more stringent and harmful interventions later. In particular, we want to have as early an indication as possible when such variants appear in Scotland or elsewhere in the UK, and the ability to develop a rapid understanding of how fast they are spreading.

We will be looking out for variants that are significantly more transmissible or better at bypassing immunity than the existing dominant strain in Scotland – because of the risk that they will lead to an overwhelming volume of cases such that, even if the variant is no more severe in terms of individual disease, it risks a high population volume of disease and hence overwhelming the NHS.

We will also be looking out for variants, which have seeded in Scotland or elsewhere in the UK, that may be significantly more severe than the current dominant strain and so likely to cause greater morbidity and mortality if able to spread in an unmitigated manner.

As well as monitoring developments internationally, including through WHO and UKHSA designations of variants, indicators that we would be particularly watching include:

- numbers of cases of the variant in Scotland and elsewhere in the UK;
- COVID-19 hospital and ICU admissions;
- numbers of COVID-19 deaths and the infection fatality ratio; and
- vaccine efficacy.

Both overall numbers and breakdowns by age group will be important for such indicators to gain a better understanding of expected harm.

We would also monitor epidemiological intelligence from areas or countries that already have experience of relevant variants (e.g. for early indications of severity of disease or increased transmissibility) as they may provide valuable early insights.

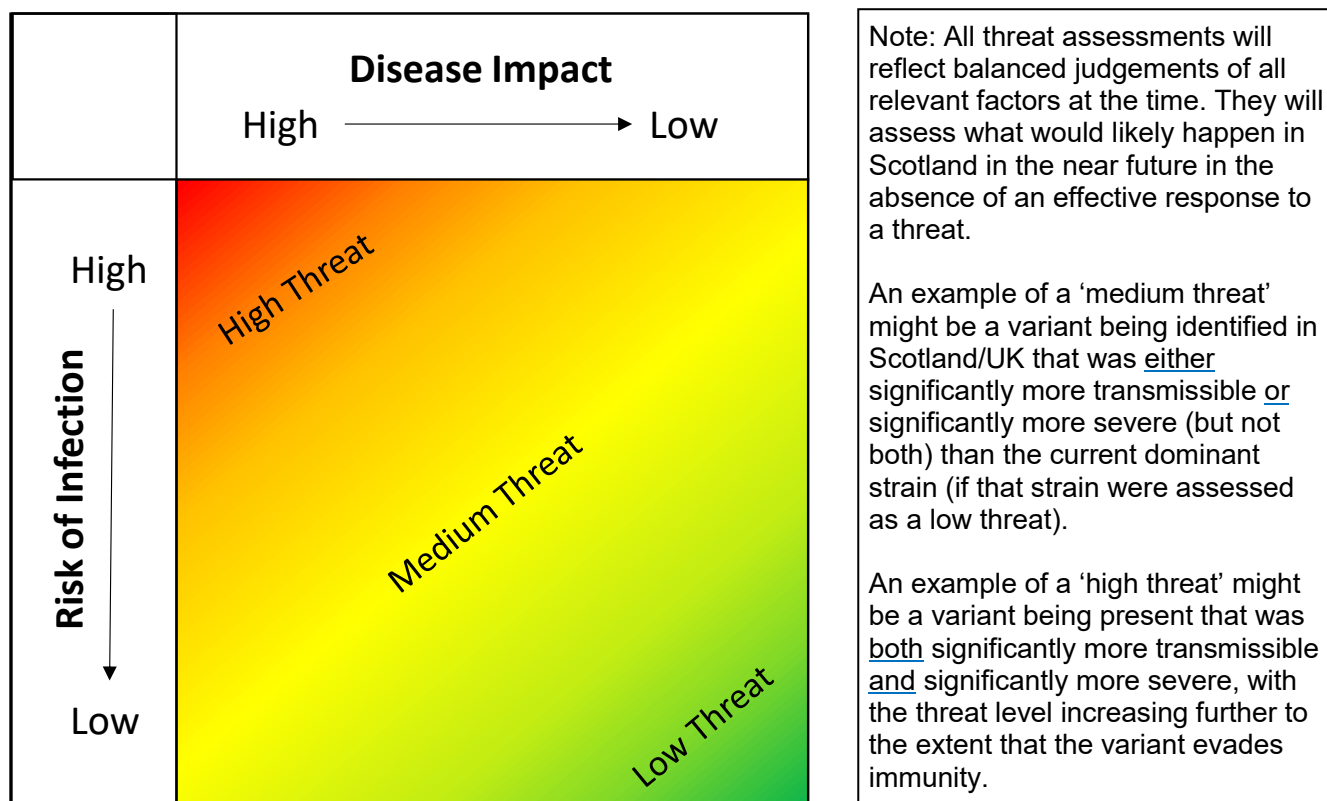
²² The harmfulness of a variant is defined here as a combination of its transmissibility and severity.

Our assessment of the necessary and proportionate response to a new variant will take account of what the available evidence tells us about its transmissibility and severity. If one or other of these were assessed to have significantly increased, then that would likely increase the assessed threat. Our assessment would also take account of factors such as our broader resilience to a more harmful variant (e.g. current NHS capacity, the likelihood of concurrent risks, such as flu, the adequacy of adaptations, and waning immunity). Careful, rounded judgement will need to be applied to take account of these various factors.

As Figure 11 illustrates, our assessment of COVID-19 threat will combine an assessment of potential disease impact and risk of infection. Assessment of disease impact (severity) will consider current and expected infection fatality rates as well as indicators of morbidity, such as Long COVID. Assessment of infection risk will consider current and expected prevalence rates and virus transmissibility. The application of judgement taking all relevant information into account will be key in making these threat assessments, and the UK Alert Levels, and any changes to them, can help to inform this judgement.

At the time of publishing this Framework (late February 2022) we judge that Scotland is currently around the top right of this matrix, which is a 'medium' threat level. This reflects a variant in Omicron that is highly transmissible (with the infection level still high) but of lower severity. Assuming that the level of infection falls - or at least stabilises in the weeks ahead - it is likely that our 'threat' level will move down to "low" as we head into the spring and summer.

Figure 11: COVID-19 Threat Matrix



Of course, with an effective response, a threat may be averted, alleviated or delayed until other measures such as surge vaccination or surge testing had been deployed, or allowing time for treatments, adaptations and other capacity to be scaled up. That could mean that the potential threat of a more harmful variant did not ultimately materialise (in the way it would have done without the effective response).

In forming judgements about the threat we face, and the implications of different potential responses, we will take advice and gather information as appropriate from a range of sources, such as the UK Alert levels, and organisations likely including:

- Public Health Scotland / NHS National Services Scotland
- Chief Medical Officer, NHS Clinical Director, Chief Social Policy Adviser, Chief Economic Adviser
- COVID-19 Advisory Group (when activated)
- National Incident Management Team (when activated)
- International and UK advisory bodies - WHO, UKHSA/JBC, SAGE, JCVI etc.

Decisions on responses will be consistent with relevant legislation. They are likely to be finely balanced judgements, made under a degree of uncertainty – for example, because it typically takes some weeks for reliable information about a new variant to emerge, whereas effective responses may need to be implemented on a shorter timescale. If we overestimate the potential harm of a variant then we risk imposing excessive protective measures and causing unnecessary broader harm. If we underestimate the harm of a potential variant then we risk having inadequate protective measures in place, leading to avoidable morbidity and mortality as well as economic and societal impacts, and potentially necessitating more extensive protective measures than would have been needed with an earlier effective response.

The exercise of careful, evidence-based judgement will always be required to ensure that responses are necessary and proportionate and therefore lawful, given the circumstances and all relevant factors pertaining at any given time. To follow a more mechanistic or prescriptive approach in which particular data crossing certain thresholds automatically triggered responses, attractive as that might appear in terms of perceived certainty and future planning, would risk the response being disproportionate and unlawful at the time of implementation. This is because such decisions on making regulations need to take into account all relevant factors.

To illustrate this point, triggers or thresholds based on case numbers might lead to disproportionate decisions if the conversion rate from cases to serious morbidity and mortality reduced. Similarly, triggers based on admissions to hospital or ICU might be disproportionate if there were ample capacity within the NHS to cope with such admissions – so the response to a given variant might differ depending on whether it arrived at the start of the summer or the start of the winter.

In addition, the current wellbeing and resilience of people and organisations, including businesses, that are likely to be subject to any increased protective measures also need to be considered, particularly as impacts accumulate over time. This underlines the ‘four harms’ approach to weighing up decisions as we acknowledge that mitigating harm in one area might increase it in another. For all these reasons, though epidemiological indicators will continue to inform our decision-

making, the application of rounded, evidence-based judgement in deciding a response will remain key.

The purpose of our response would be to slow, and potentially reverse, the spread of the virus and so reduce serious health harm. This might be, for example, to avoid a very high peak that risked overwhelming the NHS, or to buy time for (surge) booster vaccinations or for adaptations to be enhanced so as to reduce transmission or severity, or both. And, of course, regulatory measures are not the only means that we have to mitigate the harm of a new viral threat. For example, enhanced infection controls could rapidly be implemented as appropriate in hospitals and care homes and targeted public health advice could be issued to those at higher clinical risk, alongside more general public health communications and marketing to alert people to the heightened threat and encourage them to voluntarily adapt their behaviour.

Graded responses reflecting the assessed threat level

We will manage COVID-19 going forwards on the basis of four broad response categories that reflect the assessed threat. Note that the measures within each response category should not be seen as ‘all or nothing’ but rather as a graded set of options. So, for example, it would be possible to select one or two measures from a higher response category as a way to increase protection. Or, as part of the process of easing protective measures, it would be possible to release one or two measures but retain others from the category.

The more protective measures that are applied from each response category, the greater the degree of downward pressure on transmission of the virus, but also the greater the associated broader harms to the extent that economic and social activities are disrupted (acknowledging both that escalating harm from the virus would itself disrupt activity and that early intervention may reduce the need for more extensive intervention later).

As noted, applying evidence-based judgement as to the appropriate response level, taking all relevant factors into consideration, will be key. And whilst it may sometimes be the case that making fewer changes over a period is appropriate, to create more stability, at other times it may make sense to have a staged approach to either escalating or easing protective measures – always dependent on a rounded assessment of the relevant factors and circumstances.

The first category of response consists of the **routine** adaptations to behaviours and settings that are likely to become an essential part of how we all live with COVID-19 going forwards, alongside individuals taking up vaccines when invited to do so and having the testing and treatment regime in place to assess the prevalence and mitigate the impacts of COVID-19. These routine activities and measures will strengthen our resilience for a world in which COVID-19 will remain part of our lives. They are how we expect to actively manage COVID-19 when the threat from the virus is low, as we hope that it will be for long periods in the future. This response level should see minimal if any disruption to economic or social activity.

The second response category consists of temporary, **baseline protective measures** that would provide an additional layer of protection if we assess there to

be an increased risk of COVID, broadly up to a 'medium' threat, that would lead to significant increase in COVID-19 morbidity and mortality. Again, individual or groups of measures, as well as the full set, could be judged appropriate according to the assessed threat.

Judgements around the reintroduction of baseline measures would also take into account the recognised need for stability and to avoid frequently changing rules and advice concerning protective measures. It would depend on a rapid assessment both of the transmissibility and severity of the variant and of the current state of resilience to the virus (e.g. strength of adaptations, available hospital capacity, likely vaccine and treatment effectiveness etc.). In some circumstances no escalation of response may be judged necessary for a given threat; in other circumstances, additional temporary baseline protective measures may be necessary and proportionate.

The third and fourth categories of response would only be applied if we judged that we face a 'high' threat from the virus that, without a significant response, would cause a very large increase in morbidity and mortality. This judgement would take account of other relevant factors, such as the effectiveness of baseline and routine protections and NHS capacity at the time. The choice of measures (or a combination of them) would be determined in light of the characteristics and trajectory of the variant causing the threat and not all of them might be judged necessary and proportionate, according to the threat assessment. We recognise the increased impacts these types of responses have on the economy and society and therefore would only use them when absolutely required.

The third category consists of temporary, **targeted protective measures**, similar to those that were applied to deal effectively with the Omicron variant. These are likely to involve legal measures affecting certain higher risk settings and activities.

The fourth and highest response level would consist of temporary, **extensive protective measures**. This would involve legal restrictions and requirements for a wider range of settings and activities but would likely still fall well short of a 'lockdown'. We consider the need to use such extensive protective measures in the future as unlikely. Their use would mean that we judge the virus to pose a 'high' threat to a particularly large number of people, quite possibly because of the prospect of significant immune escape – i.e. evading the widespread immunity now built up in the population – a situation that we hope is unlikely to transpire, but that we must nevertheless be ready for. This judgement would again take into account other relevant factors, such as the effectiveness of other protections already in place and NHS capacity at the time.

The potential types of measures that are likely to be considered in each response category are set out in Table 1. Because we must ensure that any specific protective measure (e.g. a restriction on a particular type of setting or activity) is necessary and proportionate at the time it is applied, all of the information in the table would be subject to detailed confirmation at the relevant time. As noted, individual measures or groups of measures might be deemed appropriate – rather than the full application of every measure in each category. We nevertheless hope that this table provides a useful guide for future planning purposes by giving a broad sense of what type of protective measure might apply in what circumstances.

Table 1: Gradated response categories reflecting assessed threat level

Assessed Threat	Potential Response Categories (types of protective measure)	
Low threat	Routine Measures: Vigilance, Preparedness and Resilience (no legal measures) <ul style="list-style-type: none"> High immunity sustained through vaccination programme Access to effective treatments in line with clinical advice Behaviours and settings adapted to reduce spread (e.g. improved ventilation, appropriate guidance on face coverings) Hybrid working when possible and appropriate encouraged Effective and responsive local outbreak management Targeted testing and surveillance ongoing Travel measures may apply (e.g. set by other countries) 	Note: Protective measures would not apply in law but may still be good practice and retained in guidance.
Medium threat	Baseline Protective Measures = Routine plus: <ul style="list-style-type: none"> Testing guidance in place for people when symptomatic or asymptomatic Guidance to self isolate when positive in place Face coverings required in indoor public places and on public transport Guidance on reasonable measures to reduce risk in premises Travel measures may apply Certification required in a narrow range of settings 	Note: Measures would be selected from this response category that were necessary and proportionate – not all may be required at the same time.
High Threat	Targeted Protective Measures = Baseline measures plus: <ul style="list-style-type: none"> Requirement to work from home where possible Proportionate restrictions on certain higher risk settings and activities Protective measures in other higher risk settings . Guidance to reduce social contacts and increase physical distancing where possible. International travel requirements and restrictions may apply in relation to some countries. Certification required in a wider range of settings 	Note: Measures would be selected from this response category that were necessary and proportionate – not all may be required at the same time.
(E.g. variant with significant immune escape that increases disease severity)	Extensive Protective Measures = Baseline and targeted measures plus: <ul style="list-style-type: none"> Potential closure (or limited opening) of further non-essential settings and services Legal limits on social gatherings and events. 	Note: 'Extensive protective measures' will only ever be considered as a last resort in the most serious of circumstances

Whenever temporary protective measures are in place above the routine response level, we will keep them under regular review (e.g. every three weeks) and maintain a close watch on relevant direct COVID, broader health, social and economic indicators so that we are able to ease those protective measures as soon as it is appropriate to do so. We are likely to be monitoring a slightly different set of epidemiological indicators to inform judgements about easing measures, including:

- all available evidence to detect a decline in incidence and prevalence.
- a reduction in hospital and/or ICU bed occupancy.

As noted above, sometimes it may be appropriate to ease responses incrementally instead of jumping wholesale from 'category to category' according to ongoing threat assessment.

We expect that our responses to future threats would generally apply across the whole of the country simultaneously. However, any application of the measures would take into account their necessity and proportionality across the different geographies of Scotland, for example in relation to our island communities, at the relevant time.

Supporting Positive Behaviours and Adaptation

Notwithstanding the threat assessments and categories of response set out in the previous section, our aim should be to manage the virus on a routine - or at most enhanced protective measures - basis as far as possible. Adopting sensible behaviours and making basic, appropriate adaptations will help us to do so.

We must aim to live safely alongside COVID-19 if we can. This will require us to build a society able to balance various risks and it will involve an ongoing ask of the public and organisations to take responsibility for enhancing their safety. This includes embedding many of the protective behaviours and measures we have become so familiar with over the past two years. By doing so, we can lessen the ongoing risk posed by COVID-19 and help mitigate the impacts of more familiar diseases such as seasonal flu and other viruses. This will benefit everyone but would be of particular benefit to those at higher clinical risk.

This section describes our collective progress in terms of adhering to the protective measures that help keep others (as well as ourselves) safe before focusing in on two of the key areas of adaptation that will help us to manage COVID-19 effectively on an ongoing basis: improving ventilation and encouraging hybrid working where appropriate. It then outlines the role of the public sector, and particularly our local government partners, in supporting the positive behaviours and adaptations that we need to embed. And it outlines our communications and marketing work in this area.

Progress

The Scottish Government has continued both to support the public in adhering to rules and guidance, and to work collaboratively with local authorities, businesses, and other stakeholders to promote adherence to protective behaviours.

Since the previous Strategic Framework update, in November 2021, YouGov²³ polling shows continued strong adherence. In terms of self-reported compliance, levels remain relatively high and stable. In January/early February, as in recent months, around two thirds reported high compliance,²⁴ with over a quarter reporting 'complete' compliance (31% at 4-6 January and 28% at 1-3 February).

A fairly stable majority (65% at 1-3 February) said they feel clear about what is required of people in Scotland as the pandemic continues. Although there were some improvements in adherence to some of the protective behaviours when the additional measures/guidance were in place in early January, this was not sustained. However, levels of adherence are fairly similar now to those seen in November/December last year. For example, 90% say they do well at wearing a face covering when required (78% very well), 85% say they do well at washing/sanitising hands regularly when out and about (54% very well) and 82% say they do well at avoiding

²³ Opinion polling carried out by YouGov for Scottish Government. Fieldwork is carried out online with a sample of c.1000 adults 18+ each wave – representative of the online population across Scotland. [Public attitudes to coronavirus: tracker - data tables - gov.scot \(www.gov.scot\)](https://www.gov.scot/public-attitudes-to-coronavirus-tracker-data-tables)

²⁴ Scored themselves 6 or 7 out of 7 (where 7 represents complete compliance).

crowded/busy place (48% very well). Levels for other behaviours are lower but also stable compared to November/December.²⁵

The Scottish Government has facilitated ongoing stakeholder engagement at both Ministerial and official level with organisations across a range of sectors within the economy, the third sector, trade unions and regulatory partners. A key focus throughout has been on working with business on supporting improved adherence to baseline measures and taking the necessary regulatory actions, particularly in the face of Omicron, to better direct and support compliance from business settings by detailing the reasonable measures expected. Even as the regulatory underpinning reduces, we are committed to working with stakeholders to support safer working and resolve challenges through regular and open dialogue.

Next Steps

COVID-19 will not suddenly go away and it is likely that the virus will present us with further challenges over the months and years ahead. We can all play a part in reducing the risk posed by COVID-19 in a proportionate way; doing so collectively will help us all live safely and in a sustainable way.

Looking forward, we want to progress from people having to adhere to a set of rules that help reduce the spread of COVID-19 towards embedding a set of positive behaviours that people and organisations voluntarily undertake because they believe they are the right thing to do.

To help us to understand the challenges people face, and what action we can take to support people to address these challenges, we are exploring the establishment of a People's Panel. The Panel would enable us to explore the reality of personal responsibility and safer behaviours for people in a wide range of different circumstances. It would also allow us not only to monitor the challenges people are facing over time but also to understand elements that compound the challenges, and, crucially factors that could address these challenges. Working with the Panel would also help to provide us with in-depth understanding of how public health messaging is impacting on behaviour.

Organisations and businesses have changed substantially and invested heavily to create safer and lower-risk ways of working. While the temptation to return to a pre-COVID-19 way of operating may be strong in some parts of some sectors - and, of course, in many respects should be encouraged - the experience of the pandemic demonstrates the inherent uncertainty we will continue to face. To strengthen our long-term response to this virus, future variants and possibly other viruses ahead, we will lead the way in partnership with businesses and organisations to embed proportionate protective behaviours and create a framework for improved public health responses.

The Scottish Government will work with all sectors to support adaptation to enable Scotland's businesses, organisations and the public generally to be more resilient to

²⁵ Opinion polling carried out by YouGov for Scottish Government. Fieldwork is carried out online with a sample of c.1000 adults 18+ each wave – representative of the online population across Scotland.

future shocks. We will also develop business campaigns, clear and accessible Scottish Government guidance, update the compliance toolkit, and support voluntary action to help customers feel safe.

Businesses and other organisations recognise the positive steps taken during the pandemic and the need for them to have greater permanency in its aftermath – such as increased hybrid and flexible working, enhanced sanitisation and hygiene and improved ventilation within the workplace. Beyond this, engagement has started on longer-term adaptations to prepare Scotland to address future public health challenges – with consideration being given to: regulatory reform; business continuity and resilience planning; simplification and improved accessibility of guidance; public health training for employers and employees; and physical modification of premises to reduce the risk of infectious disease transmission.

Adaptation for businesses and other organisations

As set out in the section on Protective Measures most, if not all, COVID-19 legal requirements will no longer be in place when the threat level is low. However while there may be no legal requirements in place it will remain important for businesses to consider what they can do to help reduce the spread of the virus, protect their employees and customers and trade or operate fully in that different environment. These adaptations and behaviours help to keep the spread of the virus low but also provide confidence to customers. A recent survey showed clear signs that hospitality and retail businesses taking steps to make premises safer would make customers more comfortable (65%) and more inclined to visit (63%).²⁶ Making adaptations may also help businesses by minimising the disruption/ action required should a temporary move to increased protective measures be required.

Creating safer spaces for staff and customers is not an exact science and will vary by sector, premises and business model. However, businesses should consider some of the potential adaptations below in their own business contexts and taking account of their own risk assessments, which they should refresh regularly. We are aware that many businesses have already been adapting in some of these ways and will also have other adaptations which go beyond this.

Increased hygiene

- Ensuring hand sanitiser is available and encouraged to be used
- Ensure soap dispensers are in place and full in facilities
- Regular cleaning of tables etc.

Adjusting premises

- Improved ventilation, including mechanical ventilation where possible (see below)
- Altering premises including using outside spaces where possible
- Encouraging some distancing between customers and staff where possible

²⁶ Source: YouGov polling in Scotland conducted on 1-2 Feb.

Adjusting behaviours

- Increased levels of hybrid working (see below)
- Support staff to isolate when symptomatic
- Encourage face coverings even when not mandatory
- Testing (when available and appropriate)

These measures are not exhaustive and other specific adaptations will help in particular sectors. We will work with sectors to help identify adaptations that work for them. They will help to reduce the risk of the virus and help to keep businesses trading by reducing the likelihood that further protective measures will be required when a new threat emerges. That likelihood cannot be removed entirely, however, and where further protective measures are necessary, they will be temporary and proportionate.

Ventilation and Healthier Buildings

The nature of COVID-19 means we all need to consider, on an ongoing basis, how we: use our buildings and spaces indoors; make more use of outdoor spaces; avoid crowding; and manage flows of people. Good ventilation helps reduce the risk of transmission indoors and even simple actions such as opening windows can be effective.

Progress

We have strengthened our main [Ventilation Guidance](#) in relation to carbon dioxide (CO₂) monitors, air cleaning/purifying devices and the use of poorly ventilated spaces. We have invested up to £15 million to support this activity in our schools and early learning and childcare settings (this is on top of previous COVID-19 logistics funding of £90m that could be used for purposes including ventilation improvements). Guidance for schools has also been updated including strengthening of the required approach to ventilation and CO₂ monitoring. Updated guidance for further and higher education has underlined the continued importance of good ventilation as a key mitigating measure on campuses.

Following our COVID-19 Ventilation Short Life Working Group's initial recommendations, funding of up to £25 million was identified to help small and medium sized enterprises (SMEs) in the highest-risk settings make adjustments to ventilation, including the installation of CO₂ monitors and adaptive devices, improvements to natural ventilation and small repairs. The fund went live on 23 November 2021 and pre-work approvals have been given for CO₂ monitors, air filter/purifiers, small mechanical ventilation and window repairs.

In taking measures to ensure our public buildings and businesses are as safe as they can be we need to do so in a way that supports our continued response to climate change and our journey towards becoming a net zero nation. We need to consider how we make adaptations to our buildings and spaces that are designed to keep new infections out and control those already present by limiting transmission. Building infection-resilience to keep us safe has never been more important. We will

use learning from the pandemic to set out how buildings and settings should operate in ways that keep us healthy and safe, and provide us with good air quality and other protections.

In addition, good public health infection controls will be integral to the creation of safer indoor and outdoor environments. This includes good hygiene and how surfaces such as touchpoints (i.e. door handles) are adapted, to reduce the risk of infection.

Next Steps

- We will act to ensure that necessary improvements in ventilation will be proposed in light of the work of the Short Life Working Group on Ventilation who will provide their recommendations by the end of March 2022.
- We will continue to work across the four nations of the UK, UKHSA and international organisations to promote measures that support bio-secure environments.
- We will work with partners to develop, by the end of April, a pilot scheme that encourages those who manage buildings and settings, in the private and public sector, to display by way of signage the protective measures they have in place.
- We will review building regulations and explore how buildings of the future can have infection-resilience built into their designs.

Hybrid Working

Supporting staff to work from home, where possible and appropriate, has been an important mitigation in reducing the risk of transmission both in the work environment and during travel to and from work. It is set to remain as one of the ongoing behaviours that will help to manage COVID-19 effectively for the long term.

Progress

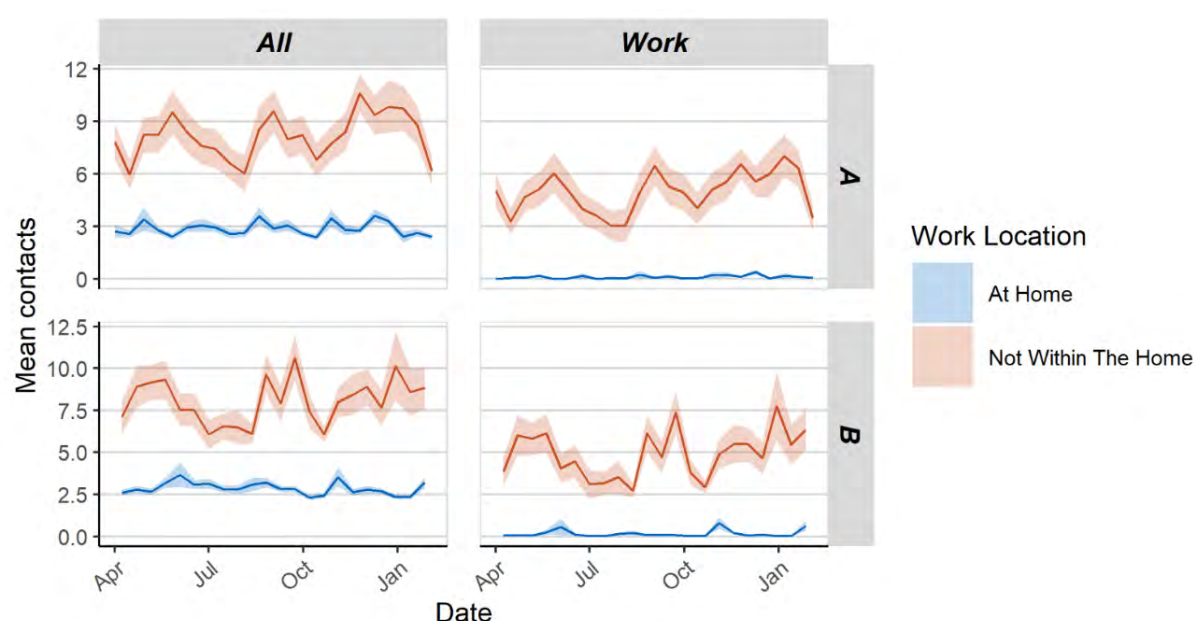
In addition to the public health benefits of working from home, a number of studies have noted [perceptions of increased productivity among employees](#) albeit contingent on technology/connectivity.²⁷ However, we also recognise that working at home does not come without cost to workers, employers and the broader economy, for example businesses reliant on office trade particularly in city centres. [Wider research](#) has noted that the absence of workplace interaction, breakdown of support networks, isolation and loneliness can cause negative impacts on social wellbeing. These points have also been made directly by businesses through regular engagement with the Scottish Government. We understand their desire to have staff back in the workplace some of the time and agree that employers and employees, in conjunction with unions, are best placed to establish what works best for them.

Figure 12 shows the difference in overall contacts and work contacts between those who work from home compared to those who have a workplace outside of the home.

²⁷ Kitagawa, R., Kuroda, S., Okudaira, H., & Owan, H. (2021). *Working from Home: Its Effects on Productivity and Mental Health*. Research Institute of Economy, Trade and Industry (RIETI).

Those who do not work from home have higher and more variable contacts than those who work from home - average contacts for those who do not work from home are approximately 2 - 3 times higher than those who work from home. This also shows that contacts within the workplace make up the majority of overall contacts for those who do not work at home.

Figure 12: Mean overall and work contacts by work location (home or away from home) for each panel (A and B) for adults in Scotland, truncated to 100 contacts per participant from SCS²⁸ (data to 9th February 2022)²⁹



While many employers have already been engaging with employees on moving to a hybrid working approach, in line with what is appropriate for their business, customers and staff, we continue to encourage a greater degree of working from home than pre-COVID-19, where this is possible and appropriate. Employers have a legal duty to make workplaces safe and to conduct risk assessments; this is particularly important for those at higher risk. The needs of those in the highest risk category should be taken into consideration when planning hybrid working – including people who might prefer home working, or those keen to return to the workplace.

Next Steps

A wide variety of working models have been explored by organisations in consultation with their workforce, such as hybrid models of home and office-based working. Working from home remains an important mitigation in reducing the spread of the virus particularly when there may be more community transmission. We will continue to strongly encourage employers to work with their employees to consider, for the longer term, hybrid working models. These may of course have benefits that go beyond the need to control the virus and for organisational resilience such as

²⁸ Scottish Contact Survey (SCS) is a longitudinal behavioural study which models contact patterns for the entire Scottish population. It asks questions to two alternating panels of people (panels A and B) who have been recruited to be broadly representative of the Scottish population.

²⁹ [Coronavirus \(COVID-19\): modelling the epidemic in Scotland \(Issue No. 80\) \(www.gov.scot\)](https://www.gov.scot/publications/coronavirus-covid-19-modelling-the-epidemic-in-scotland/issue-no-80/pages/12/default.aspx)

attracting and retaining talent, supporting wellbeing, environmental benefits and the growth of local businesses outside of urban centres.

We recognise that employers are best placed to understand how their operations work most effectively and their employees' requests for flexible working, based on consultation with staff and unions. We trust organisations to make balanced and risk-assessed decisions and we also recognise the need to consider the wider impacts working from home may have such as mental health, retail and investment in city centres.

We will continue to work with employer and business organisations and trades unions to understand the wider and longer term impacts of hybrid and flexible working as evidence and practice develops. This will help us to understand not only the economic and individual impact of hybrid working but the challenges and opportunities, the barriers to participation, the support available and recommended and where hybrid working supports our wider ambitions.

The Public Sector and the Role of Local Authority Regulators

We will work collaboratively with local government and other public sector partners to lead by example in adapting public services and spaces to be as safe as possible. There is an important role for encouraging and facilitating innovation, for example in more creative, safer and sustainable use of indoor and outdoor spaces.

Reflecting and learning the lessons of what has been most effective in supporting people, communities and businesses to adopt protective behaviours will be critical. Government at all levels will have an important role to play in capturing these lessons and maintaining the knowledge and capacity to respond to future challenges created by COVID-19.

We will continue to work collaboratively with the Convention of Scottish Local Authorities (COSLA), local authorities and other regulators who will provide critical insight into the adaptation work and the future approach to supporting safer behaviours. This includes learning and using their role as planning and licensing authorities to enable safer behaviours.

We will work with regulators to adapt our risk-based approach and ensure that they have the necessary resources to support the promotion of safer behaviours with adaptations normalised into our business communities, while having the necessary powers to address an increase in the spread of the virus at a national and local level where it poses a challenge to public health.

Communications

Scottish Government communications have supported public adherence and positive behaviours throughout the pandemic: providing vital public information on what is required as protective measures change, encouraging sustained behaviour change and delivering more targeted strands of activity to support specific audiences and needs.

Progress

November/December 2021 was a period when people were expected to be socialising and mixing more than normal. Vaccine immunity was diminishing for certain cohorts and infection rates remained high. The 'Living Safely' communication strategy - developed from audience insight and designed to help establish a longer-term social norm for protective behaviours – was already in place. With the arrival of Omicron it was adapted to be more directional and to reflect the updated asks of the public. It was delivered through the 'Living Safely This Winter' campaign, focusing on the behaviours we all needed to adopt over the festive/winter period to protect each other and stay safe.

Supporting materials were sent to businesses in advance of the main campaign and marketing campaign toolkits were deployed through public sector, third sector and private sector networks to reflect 'Living Safely' messaging. A number of other communications campaigns supported the public during the winter period, including:

- Right Care Right Place: to help the public access the healthcare they need through the right channels.
- An education campaign: to promote the importance of both ongoing testing and testing prior to returning to places of education in January 2022 (delivered via social media platforms, Parent Club and Young Scot).
- A number of COVID-19 recovery campaigns including ongoing activity to provide practical and positive advice to the general public about how to look after their mental wellbeing during the pandemic and a 'Tenancy Rights' campaign to protect renters from eviction and mistreatment.

Next Steps

[Opinion polling](#) in January and February³⁰ showed a continual increase in optimism among the general public from the situation in December, and at 45% (4-6 January) there was slightly more positivity about the year ahead than seen in January 2021 (40%). Although decreased to the lowest level seen, around two-fifths were still worried about the situation (43% at 1-3 February), and the wider impacts (anxiety, loneliness, effect on mental health, financial worries) were still much in evidence. Qualitative research carried out on 11 January³¹ made clear the fatigue and weariness that is felt, both with the pandemic and ongoing protective measures. However, this research also suggested that many people are generally accepting of the need to continue to adopt certain protective behaviours while COVID-19 poses a threat - seeing them as commonsense, practical actions that enable life, as they would like it, to carry on.

³⁰ Opinion polling carried out by YouGov for Scottish Government. Fieldwork is carried out online with a sample of c.1000 adults 18+ each wave – representative of the online population across Scotland.

³¹ Qualitative research was undertaken with a small-scale sample of people across Scotland (6 online group discussions and 4 in-depth interviews, by JRS, an independent research agency), ranging from 18 to 75 years old, weighted towards 18 to 34 year olds. All scored themselves between 6 and 9 out of 10 on a scale of compliance with the guidance in place (10 representing total compliance).

[Opinion polling](#) on 1-3 February³² confirmed the qualitative findings: 76% agreed that they are happy to follow some rules and guidance if that means they can do the things that matter to them, while only 11% disagreed. This audience insight and qualitative feedback confirmed that the 'Living Safely' communication strategy remains powerful and valid. In the short term this is being delivered through 'Living Safely for Us All' which reinforces the importance of adopting the key behaviours on a sustained basis – to establish a safe positive norm of living safely with COVID-19.

The vaccine booster campaign is also live across a range of channels to encourage those (in targeted groups) who have not yet had it to come forward for their booster. Further work to support segments of the population as the pandemic continues and to help them do their best to adapt to the challenges it presents will also be delivered through:

- Ongoing activity to support positive mental health, including development of a new online resource.
- The Supporting Parents of Teens campaign, developed to help parents and carers support their teens through common emotional challenges, many of which have been exacerbated by the pandemic.
- Further phases of the Money Support Scotland campaign, designed to address systemic inequalities made worse by COVID-19 - signposting to trusted partners able to offer free, impartial financial advice.

We will supplement these campaigns with communication through social media, press briefings and wider communication channels from government and partners.

For the longer term, the 'Living Safely' communication strategy is under review and will be updated. Based on audience insight, the adult tone reinforcing behaviours by providing the rationale for doing them, which is currently in use, will continue to form a core part of the approach. The focus will be very much on embedding the required behaviours into our everyday lives using clear and simple messaging to help the public understand what they can choose to do and why. Any future activity will be informed by ongoing research and evidence. There also continues to be a focus on developing and improving content on the Scottish Government website to support public understanding of, and compliance with, public health guidance.

Communications will also support the wider COVID-19 recovery, and collaboration with organisations such as Scottish Enterprise, Young Scot and Black and Ethnic Minority Infrastructure in Scotland will continue, as will engagement with a range of organisations that can help to disseminate messaging to those they represent.

³² Opinion polling carried out by YouGov for Scottish Government. Fieldwork is carried out online with a sample of c.1000 adults 18+ each wave – representative of the online population across Scotland.

Helping to Manage COVID-19 Internationally

Progress

Following a review of the international travel requirements, the four nations agreed on 24 January to reduce and simplify requirements for travellers entering the UK. The main changes came into force on 11 February. The changes mean that eligible 'fully vaccinated' travellers are no longer required to take any tests before travelling to, or after their arrival in, the UK, and only have to complete the Passenger Locator Form (PLF) beforehand. For international travel purposes, 'fully vaccinated' means having completed a primary course of the vaccination. The PLF is to be simplified by early spring 2022. All children under 18 benefit from the same privileges as 'fully vaccinated' adults, regardless of their actual vaccine status.

Protective measures have also been eased for unvaccinated passengers, who are now required only to complete the PLF, take a pre-departure test and book a day two PCR test. Additionally, they will no longer have to self-isolate upon arrival in the UK.

Next Steps

While there are currently no countries on the red list of highest risk countries and territories, the UKHSA continues to monitor international data and will escalate any concerns to the four nations in line with a revised agile global scanning risk assessment process. Further consideration will be given in late February/early March to alternatives to Managed Quarantine Service hotels for any travellers arriving from a country that is on the red list in future.

The next phase of the review of international travel measures will focus on what the response should be to the identification of a future variant of the virus. This will include the definition of 'fully vaccinated' in an international context and the development of a border contingency toolkit being carried out by the UKHSA. We will continue to seek clinical input, and discuss on a four nations basis, before making any changes.

The UKHSA has recently updated its risk assessment methodology for Border Surveillance. It will continuously monitor threats, but will now provide summary reports for UK Government departments and Devolved Administrations on a fortnightly basis, or faster if any particular concerns come to light.

In the longer term, the UK aims to enhance global surveillance capabilities to maximise detection of variants. This includes working with the WHO and other public health bodies on the International Pathogen Surveillance Network (IPSN), supporting a small number of regional hubs and countries bilaterally to build genomic sequencing capability and capacity (New Variant Assessment Platform, NVAP) and continuing to offer rapid sequencing capability where needed. Scottish Government Ministers are committed to working with the UK Government, other Devolved Administrations, and delivery partners in developing robust surveillance architecture. We will retain robust contingency plans for new variants which present significant risk to public health. To inform our longer-term strategy we are working on a four-nations basis with business and other stakeholders to move away from a 'one-size-

fits-all' red list approach to a more agile set of contingency measures for dealing with reasonable worst-case scenarios, based on analysis of the advantages and disadvantages of previous measures. This review will also explore options to move away from relying on managed quarantine hotels to a home isolation model.

International Vaccination

We place great importance on Scotland being a good global citizen. Since the start of the pandemic we have worked with our partner countries in the Global South to support their response to the pandemic.

Progress

We have invested £3.5 million of our International Development Fund in COVID-19 response initiatives in Malawi, Rwanda, Zambia and Pakistan. We have provided support for vaccine preparedness, delivery, distribution, roll-out and online healthcare education to counter hesitancy through UNICEF, who work in conjunction with our partner country governments. In 2021 we also provided oxygen concentrators and ventilators to our African partners to support their COVID-19 responses and additional supplies of medical equipment and products, including vital Personal Protective Equipment (PPE) through the NHS Scotland Global Citizenship Programme. In addition, we funded an oxygen plant facility installed at Chitambo Hospital, Central Province, Zambia, with provision for all clinics and health centres in the surrounding area.

We continue to support collaboration between the University of Glasgow's Immunology Department and the Kamuzu University of Health Sciences in Malawi, including new COVID-19 funding in 2021 for immuno-phenotyping and genomic sequencing, which will help to identify new variants and improve disease control.

Next Steps

We will:

- Offer to share Scotland's experience in delivering a mass vaccination programme with the Governments of Malawi, Zambia and Rwanda.
- Provide crucial COVID-19 medical supplies to partner countries wherever we can to support the treatment of the illness.
- Provide multilateral partners with assistance to ensure effective vaccine programming in our African partner countries, including a £1.5 million contribution to UNICEF in this financial year specifically to target support for COVID-19 vaccines.
- Work in collaboration with multilateral agencies and partners in the Global South to call for improvements in vaccine equity globally, and continue to invest funding in initiatives to support equitable access to COVID-19 vaccines in Sub-Saharan African partner countries.

Supporting People at Highest Risk and Reducing Health Inequalities

A key element of our overall strategic approach going forwards must be to support and protect people who are at higher risk from COVID-19 – either because of their own health conditions or because they are less able to take preventative measures. Related to this we must ensure that we have both effective Personal Protective Equipment available and Infection Prevention and Control procedures in place. More broadly – over the medium to long term - we can help the population to become less vulnerable to serious health harm from COVID-19 if we can reduce some of the long-standing health inequalities, which is where many of our current efforts are focused.

Supporting People at Highest Risk

Throughout the pandemic we have provided bespoke advice, information and support to help protect the approximately 180,000 people identified as being at highest risk from COVID-19.

We must adapt to living with COVID-19 while remembering that those who have been on the Highest Risk List may need more time, care and consideration to get back to a more normal way of life. There is strong evidence to show that the vaccine is offering significant protection and preventing people on the highest risk list from becoming severely ill if they are infected with COVID-19, however understandably many may feel particularly fearful about what adapting to 'living with the virus' means for them.

We know that many people, who may be at higher risk or more anxious, may be worried as we lift restrictions. Therefore, we will for the time being continue to provide guidance and support to those who may feel more vulnerable, and communicate that, for many people initially considered to be at highest risk from COVID-19, that is no longer the case.

Given the wide range of circumstances and health conditions of people on the Highest Risk List, ensuring personalised advice and support is available to each individual on the list is an important part of this transitional period. GPs and clinicians who best know the circumstances of those people at highest risk will continue to be the first port of call for individual clinical advice. For some time now, we have advised people on the Highest Risk List to follow general population-wide advice and guidance unless advised otherwise by their clinician, and we will now consider if people need to continue to be on a Highest Risk List.

Progress

Our successful vaccination programme has helped us prioritise and protect vulnerable groups, in line with JCVI guidance. This includes over 90% of the people with severe immunosuppression who received a third dose prior to their booster so they could reach similar levels of protection to the general population. We will continue to communicate how people's risk has changed as a result of the vaccination programme and Omicron causing less severe illness across all groups.

As a Government, we have regularly engaged with people at highest risk since the pandemic began to understand the specific needs and considerations of this group, and more than 13,000 highest risk individuals responded to our most recent survey by Public Health Scotland.

Having listened to people on the Highest Risk List we have launched a scheme to allow anyone who feels anxious to signal to others that they would like extra space and care taken around them in public places. The [Distance Aware scheme](#) was developed by the Bevan Commission and adapted by the Scottish Government as a voluntary initiative designed to complement any other protective measures which remain in place. It is open to anyone who feels this would give them greater confidence for whatever reason when they are out and about in public places and the workplace.

We know that the mental and physical health of people at highest risk from COVID-19 has been particularly affected, which is why we are working to develop support for those who need additional help to recover, to reconnect with people and things they were doing before the pandemic, and to benefit from the lifting of protective measures.

We are also asking employers to consider the individual needs of people on the Highest Risk List as they implement hybrid working models. We have developed workplace guidance specifically for people at highest risk, including employer responsibilities, at mygov.scot/covid-highest-risk/work.

Many people on the Highest Risk List, including people who were asked to shield in the early stages of the pandemic, have told us about how isolated and lonely they have felt. We have funded a free support service run by the British Red Cross, called Connecting with You. It is available to all people aged 18 or over in Scotland who are experiencing issues associated with loneliness and helps people to rebuild their independence.

Next Steps

We will continue to ensure people at highest risk know where to turn if they need further guidance. Clinicians and GPs will continue to provide advice tailored to the personal circumstances and conditions of each individual on the Highest Risk List as they would have before the pandemic. We will:

- provide further advice and information to support this group, particularly on issues related to mental health and loneliness;
- working with our Clinical Advisory Group, to provide support to those who no longer need to be on the list where the evidence indicates that they are no longer at highest risk; and
- continue to respond to scientific and clinical advice regarding COVID treatments, making sure that those who we know will benefit most from them are able to access them; and,
- continue to look at ways to identify and support people who may be at highest risk, taking into account potential new variants and emerging evidence.

Our aim is to ensure that people who have been on the Highest Risk List are supported, empowered, and included throughout this calmer period into a more normal way of living. It has been nearly two years since we asked people to shield, and it is crucial that they are now supported to benefit from the lifting of restrictions as much as everyone else.

Adult Care Homes

People living in adult care homes, many of whom are older and/or are living with multiple long-term medical conditions, have been severely affected by COVID-19 due to the high risk of exposure to infection and higher clinical risk of severe disease and mortality. In response to this higher risk, a range of protective measures has been recommended to limit the spread of COVID-19 including those on visiting in and away from the home. The non-COVID harms from these protective measures include diminished mental wellbeing, reduced mobility and lack of family connection.

People living in care homes, which are essentially their homes, should be supported to enjoy fulfilled, meaningful lives free from restrictions as far as possible. Even during outbreaks, unless there are exceptional circumstances, the care home should support residents seeing friends and family and participating in activities in and away from the home. Where protection measures do need to be in place these should be proportionate and only be in place for the shortest possible period.

The ongoing response to COVID-19 will need to provide flexibility for local responses to outbreaks, and support effective and consistent risk assessment that balances the risks from infection with the harms caused by restrictions, and the wider impact on the system of care home closures.

Reducing risk and improving outcomes in care homes will depend heavily on enablers of workforce, technology and data, and ethical commissioning. That will be essential for the sector as it recovers and renews from COVID-19 and looks to the future with the creation of a National Care Service.

Progress

Policy and guidance to support care home residents and staff are based on clinical evidence around the risk to people in vulnerable settings. At the start of the Omicron wave, a number of precautionary protective measures were introduced including daily LFD tests for staff in care homes, household limits on visitors and continued promotion of vaccination including boosters, which will have contributed to a lower rate of transmission and death compared to previous waves (booster uptake for care home residents is currently at over 90%).

The named visitor policy during COVID-19 outbreaks has been implemented with growing support from the sector, and this has assisted the wider implementation of [Open With Care](#) visiting guidance and also ensured that the majority of care homes continue to support visiting during the Omicron wave.

Challenges remain and the harms associated with restricting visiting and other routine activities have influenced the recent decision to remove precautionary self-isolation for care home residents on admission to care homes who have not had COVID-19 or not been a contact, and to reduce isolation periods for residents who are COVID-positive or have been a contact from 14 to 10 days.

However, there remain some protective measures in care homes which differ from the general population. This is due to evidence of increased risk to those living in a communal setting where many individuals are living with frailty or multiple long-term medical conditions or are elderly with an immune system that is less effective against COVID-19.

Nevertheless, we want care homes to return to normality as soon as possible so it is important that any protective measures are reviewed regularly, with the aim of bringing them into line with those for the general population.

Next Steps

The future management of COVID-19 in care home settings will continue to build on what has been learned about the critical importance of infection prevention and control (IPC) and PPE, and the benefits of vaccination. Having a proportionate response that reduces harms to wellbeing and health, will help to ensure that care home residents are supported to live their lives as free from restriction as possible.

We will improve healthcare outcomes for care home residents by developing, delivering and facilitating the implementation of a new healthcare framework led by our Clinical and Professional Advisory Group (CPAG) for adult social care. It will be a blue print for the health and care system that will focus on prevention, anticipatory unplanned care through to palliative care, and will take account of the evolving impact of COVID-19 for the foreseeable future. A critical enabler will be the effective and seamless working of multiple-disciplinary teams that put people at the centre.

Health outcomes for people with learning disabilities have been particularly affected by COVID-19. A new subgroup of CPAG will explore how to support care homes and other settings to improve outcomes and reduce ongoing risk from COVID-19 and associated harms.

We will work with PHS and ARHAI Scotland (Antimicrobial Resistance and Healthcare Associated Infection) to agree thresholds for declaring outbreaks, with a national risk assessment tool that supports consistency and confidence in local decision-making. It will also provide transparency for those working in the sector, residents themselves and friends and families. We will continue to learn from the experience of preventing and managing outbreaks through a follow-up exercise to the Root Cause Analysis report published in November 2020.

We will work with ARHAI Scotland, NHS Education for Scotland (NES), Scottish Social Services Council (SSSC) and the Care Inspectorate to ensure the workforce has the right tools, training and support to adopt the IPC standards.

We will work to ensure that residents are supported to see the people who are important to them and to participate in activities within and outwith the home. In addition we will continue to implement our commitment to deliver Anne's Law through the following non-legislative and legislative measures. These include:

- working with the Care Inspectorate to update and strengthen the Health and Social Care Standards and have proposed two new standards with a strong focus on choice and visitation rights; and
- continuing to work with stakeholders on the Open with Care visiting guidance to emphasise that visiting should be as normal as possible.

We will continue to promote and monitor vaccination, including boosters, for residents and staff. Social care staff should also receive a vaccination for flu on an annual basis. We will review testing arrangements for staff in care homes and review isolation periods for care home residents who have COVID-19.

Infection Prevention and Control

Progress

Infection Prevention and Control remains an important part of our management of the virus. We developed guidance in a responsive manner with rapid literature reviews of evidence conducted by NHS Services Scotland Antimicrobial Resistance and Infection Prevention and Control (ARHAI) and supported by the Clinical Nosocomial Review Group (CNRG) commissioned by the Chief Nursing Officer.

The existing National Infection Prevention and Control Manual (NIPCM) was supplemented by additional addenda for specific health and social care settings. These were revised to become a single Winter Respiratory Infections Addendum.³³

Infection Prevention and Control guidance was developed on a UK four nations basis and reflected in our own Scottish guidance.

The pandemic demonstrated a need for enhanced IPC in community settings and in acute settings, with some aspects of routine surveillance and monitoring being paused to allow staff to focus on meeting the IPC needs required by the whole health and social care sector.

Provision of PPE was initially challenging both in supply and in staff knowledge of its use. We worked collaboratively with ARHAI to support a range of policy areas with IPC expertise to inform decisions on appropriate PPE requirements and education to support its use. We worked with ARHAI, the Care Inspectorate, Healthcare Improvement Scotland and staff to support education and communication regarding

³³ [National Infection Prevention and Control Manual: Winter \(21/22\), Respiratory Infections in Health and Care Settings Infection Prevention and Control \(IPC\) Addendum \(scot.nhs.uk\)](https://www.scot.nhs.uk/nipcm/addendum/)

COVID-19 modes of transmission and PPE requirements through the use of webinars, posters and social media campaigns.

Next Steps

With a largely vaccinated population and with further treatment options available to us, the level of risk presented by infection with the virus reduces. ARHAI will withdraw the Winter Respiratory Addendum and return to the NIPCM and business as usual. We have proved that we have the expertise and ability to respond quickly to changing levels of threat posed by this and any other potential infection should the need arise.

We will continue to work on a four nations basis to inform and develop IPC guidance for Scotland. We will continue to develop policy and guidance for health and social care settings in a collaborative manner with ARHAI, PHS, Occupational Health, PPE policy unit and others.

We will seek to use sound IPC principles as an enabler to safe and compassionate care wherever it is delivered. We will ensure that IPC guidance and access to IPC expert support is available across health and social care. This will be especially critical as we develop a new National Care Service.

We will refocus on reducing avoidable healthcare associated infections and antimicrobial resistance through resumption of surveillance and quality improvement programmes. We will work with colleagues to reduce avoidable harm through inappropriate or over use of PPE. We will work with NHS Education Scotland to strengthen IPC knowledge in the workforce at all levels. The learning we have gained through the pandemic will inform future service design and even the design of the buildings we deliver services in.

Personal Protective Equipment (PPE)

The Scottish Government will develop, throughout 2022-23, a new approach to how the public sector procures and supplies PPE in Scotland, with this coming into operation in 2023.

We will plan for new approaches to pandemic PPE which will ensure that we learn from experience, promote innovation, and have strong, sustainable foundations for any future epidemic or pandemic. To ensure that we are prepared for any future requirements for PPE, we will:

- ensure future PPE pandemic supply and develop a strategy to ensure Scotland is ready for a future pandemic whenever it may occur;
- work to protect the new Scottish PPE manufacturing capacity and capability;
- oversee the implementation of positive changes to the provision of PPE in Scotland and make PPE more sustainable;
- work to minimise wastage and maximise the benefit of PPE purchased; and

- ensure all areas have considered the lessons learned, and apply this knowledge throughout the work being undertaken.

Reducing Health Inequalities

As Scotland emerges from the COVID-19 pandemic we urgently need to address the pre-existing health inequalities that have been exposed and exacerbated. The pandemic has produced uneven impacts across a range of outcomes for a number of groups. These include households on low incomes or in poverty, low-paid workers, children and young people, older people, disabled people, minority ethnic groups and women. These groups also overlap, which may compound the impacts for some.

We have a national mission to increase how long people in Scotland live in good health, focusing on those facing the most disadvantage. We need to do much more to support people in the most deprived areas, where healthy life expectancy is 24 years lower than in the least deprived.

Reducing health inequalities is therefore at the heart of our COVID-19 Recovery Strategy. It is also a key consideration in the remobilisation and redesign of our health and social care system. So as we renew and recover as a society, we will ensure the necessary resource is directed at addressing health inequalities and their underlying causes.

Our inclusive COVID-19 vaccination programme and our inclusive approach to Test and Protect are both examples of where we have built strong foundations that will contribute to enhancing our public health response and ensure it is equipped to continue managing COVID-19, support our recovery from it, and address longer-term population health challenges. But there is more to do and we will grasp the opportunity to address many of the deep rooted health inequalities COVID-19 has exposed. Work on enduring transmission will have an important role in the understanding of factors leading to, and possible mitigations of, enduring transmission in Scotland to reduce inequality impacts.

The impact of the pandemic is driving increased demand and complexity across all services and particularly in the most deprived areas. General Practice supports people in hearts of communities who may not be in touch with other services. It has a unique and key role to play in addressing health inequalities and tackling child poverty: improving population health and employability

We plan to build on our policies of providing social and financial inclusion support and advice under the General Practice roof (through Community Links and Financial inclusion Workers) through the work of the Primary Care Health Inequalities Short Life Working Group.

Taken together, this work will support patients experiencing multiple and intersecting socio-economic inequalities to improve health and wellbeing outcomes and employability.

We are taking bold population-wide approaches to reduce the significant harms of tobacco, alcohol and unhealthy food and drinks. Examples of this include:

- Bringing forward legislation to restrict promotions of less healthy food and drink
- Tackling alcohol consumption and harms, particularly among high-risk groups
- Developing a refreshed Tobacco Action Plan and continue to provide £9 million a year to health boards to fund smoking cessation services in the most deprived areas
- Doubling investment in sport and active living to £100 million a year by the end of the Parliament ensuring more people can enjoy active lives, improving physical, mental and social health.

We are also tackling inequalities in the uptake of health screening. Screening is one of our most important prevention tools, so it is vital that everyone who is eligible to take part has a fair opportunity to do so.

We recognise that factors that impact on people's health and wellbeing go beyond what the health and social care system itself can deliver. Understanding that socioeconomic inequalities drive health inequalities, our public health efforts are complemented by wide-ranging cross-government action. This includes actions to end poverty; increase fair access to employment, education and training, and improve our physical and social environments.

An intelligence-led approach to tackling racialised health inequalities

Minority ethnic groups have been disproportionately affected by the economic impacts of the pandemic because of their employment and household circumstances.³⁴ Minority ethnic people are also at greater risk of severe illness and death from COVID-19. Analysis in November 2021 showed that compared to people with White Scottish ethnicity, deaths amongst people with Pakistani ethnicity were 3.7 times as likely to involve COVID-19. Inequalities were also found for people with Chinese ethnicity (1.7 times as likely), Indian ethnicity (1.7 times as likely) and Other Asian ethnicity (3.0 times as likely).

We are determined to show leadership and address the systemic racialised inequalities. We also know that we need focused and robust actions. Improving equity in healthcare for minority ethnic groups has been at the heart of our work since the pandemic began. In response to the emerging evidence on the uneven impacts of COVID-19 on minority ethnic communities, the Scottish Government convened an Expert Reference Group on COVID-19 and Ethnicity. The Group provided advice and recommendations on data, evidence, risk and systemic issues. In September 2021, the Scottish Government published its Race Equality Immediate Priorities Plan setting out an 18-month work plan to ensure that minority ethnic communities have a fair recovery from the pandemic.

³⁴ To learn more, read [Which occupations have the highest potential exposure to the coronavirus \(COVID-19\)? - Office for National Statistics](#)

Good progress has already been made on several of the health focused commitments within the Plan. In particular, we have made significant strides to embed inclusion into our COVID-19 vaccination programme as well as our future vaccination and immunisation programmes. This includes ethnicity data being collected which will further support the planning of services and outreach.

Within Scotland, improvements are needed in ethnicity data quality in order to accurately assess the impacts of COVID-19 on minority ethnic populations. Further work is underway across Government to improve the collection and use of ethnicity data to better understand and address inequities in health access and outcomes for minority ethnic communities in Scotland.

A place-based approach to tackling inequalities at local level

We are working with local communities to cultivate person-centred approaches aimed at preventing ill health and reducing inequalities by addressing their root causes. By making smarter use of public health data and our public health workforce we can inform local level decision making. This will ensure that, together, we can improve the health and wellbeing of communities who experience the greatest inequalities. This will include supporting our health and social care providers to become active 'anchor institutions' and build wealth in their community. We are looking to embed community-led health improvement into local public services through, for example, social prescribing.

We are exploring how to wrap services around families and developing a model of family support based on integrated multi-disciplinary teams. These teams will provide accessible drug and alcohol services, community mental health services and family support wrapped around Deep End GP practices alongside support to help people enter and remain in employment.

Mitigating Broader Harms and Supporting Recovery

This section of the Framework outlines action to support both the mitigation of harm and broader recovery across our businesses, health and social care, and other public services. The information set out below is not exhaustive and highlights progress and next steps across a number of areas of activity that are being developed in further detail within our COVID-19 Recovery Strategy.

Business

Progress

Since the start of the pandemic, we have worked with businesses to support them through some of the most challenging times, during which the need to reduce transmission of the virus affected their ability to operate. We recognise that businesses across Scotland have gone above and beyond in adapting to the challenging circumstances brought about by this global pandemic in order to reduce the risk to their staff and customers.

To date, businesses have benefitted from more than £4.4 billion in support from the Scottish Government. This includes direct grant funding to businesses that were closed or required to change their operations while restrictions were in place, and targeted funding for businesses in sectors most significantly impacted.

It also includes COVID-19 non-domestic rates reliefs which have saved businesses around £1.6 billion in reduced rates bills since 1 April 2020. The Scottish Government has offered 100% COVID-19 rates relief for the past two years without any cap, and we were the only government in the UK to do so. We are preventing a cliff edge return to full liability for businesses in the retail, leisure and hospitality sectors on 31 March 2022, by continuing relief at 50% for the first three months of 2022-23, capped at £27,500 per ratepayer, which will help businesses recover.

To date we have spent almost half a billion pounds more in support of Scottish businesses than the funding we received from the UK Government for that purpose.

Throughout the pandemic we have revised and streamlined guidance working closely with sectors affected. Since the move beyond Level 0 in summer 2021 we have removed much of the sectoral guidance and instead focus primarily on one set of safer workplaces guidance.

We have also included all businesses in Scotland with 10 or more employees in workplace testing. Any business enrolled in the scheme can access free LFD tests. More than 750 businesses have signed up for workplace testing in Scotland, covering approximately 120,000 employees.

Next Steps

The Scottish Government committed a further £375 million support package for businesses impacted by the necessary measures introduced to control the spread of the Omicron variant. This package includes £200 million reprioritised from the

Scottish Government's expected consequential budget and £175 million made available by the Treasury.

From this funding package, £80 million has been allocated to the COVID Economic Recovery Fund. This will give councils the flexibility to target funding to their local businesses and communities and will support economic recovery across the country as we move to a new phase in the pandemic.

There is currently no budget cover in financial year 2022-23 for further business support, so providing similar support if future restrictions were introduced would require additional funding from the UK Government to be made available.

Many businesses have already made changes to the way they operate to reduce the risk of transmission including changing the physical layout of their premises, making use of outdoor spaces and reducing the risk of crowding.

We know that improved ventilation can make an important contribution to reducing the risk of transmission, and we have made £25 million available through the Business Ventilation Fund to help businesses with the cost of improving ventilation in their premises.

Businesses more likely to be affected by temporary protective measures, should harmful variants occur, may need to consider the impact of reduced revenue at times as part of their planning.

We will continue to refine guidance based on the current position, providing clarity on what is expected of businesses so they can plan effectively.

NHS Resilience

The NHS has experienced significant pressure as staff have worked tirelessly to deliver care and treatment to the people of Scotland. The focus has been on: maximising capacity; improving outcomes for patients; caring for staff and improving access to and discharge from hospital. Our NHS will remain ready to adapt and respond to COVID-19 while taking forward work to deliver recovery.

Progress

[The NHS Recovery Plan](#) was published in August 2021 and will be the cornerstone of our work to respond to the significant non COVID-related health and social care needs which have continued to build up over the last two years. A key aspect of our recovery will be accelerating innovation and the transformation of services supported by the Centre for Sustainable Delivery.

Within the NHS Recovery Plan key actions are set out that will support recovery through:

- maximising staffed capacity in hospitals and community services by continuing to extend the redesign of urgent care and hospital at home, increasing the availability of self-care with remote monitoring and digital technologies;

- increasing workforce through recruitment; improving education, training and development, including the accelerated recruitment of 1,500 additional staff for the National Treatment Centres;
- extending and optimising planned care capacity, to tackle the growing backlog in elective and cancer treatments as well as diagnostics, including endoscopy services, as set out in our recent Endoscopy Plan;
- innovation and redesign of services to help staff deliver high quality care and treatment by allowing more people to manage their condition at home and to be able to carry out pre and post-operative assessments remotely; and
- increasing the use of digital technology to enhance accessibility to services.

The Plan also sets out how we will create transformational and lasting change in mental health services, across acute and primary care sectors including investment to expand capacity in Child and Adolescent Mental Health Services (CAMHS); scaling up new digital treatments and therapies to ensure these are also accessible in rural areas; and expanding access to frontline services which benefit people with dementia and their families after a diagnosis.

In primary care, in addition to our existing commitment to deliver 800 additional GPs by 2028, we will support the extension of Board-delivered pharmacy and nursing support in all 925 of Scotland's General Practices to help to alleviate pressures on GP services while ensuring we all get the care and support we need from a qualified professional.

While we have made some progress, the recent wave of Omicron has impacted on the NHS Recovery Plan and we will work closely with our NHS Boards and their social care partners to deliver on the key priorities.

That transformation work will sit within and alongside a longer-term comprehensive programme of reform being taken forward through the Care and Wellbeing Portfolio and its four constituent programmes: Integrated Planned Care; Integrated Unscheduled Care; Preventative and Proactive Care; and Place and Wellbeing. This programme is being designed, in collaboration with partners across the public and third sectors, to respond to the impact but also the opportunities that have arisen during the pandemic. To deliver a more sustainable health and care system it will focus on improving population health and tackling inequalities and not just dealing with symptoms.

Next Steps

We will take the learning from the response to the recent wave of COVID-19, and nurture and support the creativity and innovation of our staff, to deliver improved resilience and long-term sustainability across our health services.

Work on technology enabled care and the development of virtual capacity has been developing rapidly and offers benefits in terms of both immediate resilience and longer-term recovery. There are a number of community-based pathways currently under development, including remote health monitoring services designed to help as

many people as possible to safely manage their COVID-19 symptoms at home, supporting early detection of deterioration and reducing pressure on hospital bed capacity.

A key element will be taking forward the work on delivering care as close to home as possible, moving more acute care and support beyond hospital walls, supported by a programme to expand and increase Hospital@Home services. Working with Healthcare Improvement Scotland, we will be providing support to 20 partnerships to start or expand Hospital@Home over the coming months. The Hospital@Home model reduces the disruption to patients' existing formal and informal care and support arrangements through the addition of acute-level care delivered by multidisciplinary teams of healthcare professionals in patients' homes.

Combined with existing programmes, such as the Interface Care programme that aims to avoid unnecessary admission by optimising ambulatory care and Redesign of Urgent Care, these innovative approaches will enable the NHS to adopt a more flexible response to fluctuations in demand and ensure care is delivered as close to home as possible.

Investment in support for staff wellbeing is an essential and vital component of recovery. We are supporting: a National Wellbeing Programme, including a dedicated hub and helpline; Workforce Specialist Service and psychological interventions and therapies; along with time and training for staff to support each other as teams, and practical support like rest spaces.

Alongside compassionate leadership, we also recognise that staff working in specific areas may need more tailored support and work is under way to meet the particular needs of staff in areas such as intensive care, nursing, primary and social care.

Primary Healthcare

Progress

Nine out of ten contacts with Scotland's healthcare services are with primary care services. General practices, community pharmacies, dentists as well as NHS24 and the Scottish Ambulance Service are working tirelessly to meet people's needs. To support these services to meet the increased demand:

- We have provided £15 million sustainability funding to GP practices to support effective hybrid working including more face to face, extra GP sessions and practice nurse time to help clear the backlog.
- We are investing an additional £20 million in dentistry through increased fees to incentivise dentists to see more patients as well as £5 million of funding for ventilation improvements and £7.5 million for the purchase of new dental drills.
- We are rolling out the Pharmacy First Service designed to encourage everyone to visit their community pharmacy as the first port of call for all minor illnesses and specific common clinical conditions.

- We have provided investment of £20 million to help the Scottish Ambulance Service to increase service capacity, improve response times and improve staff wellbeing.
- We have provided increased funding of £20 million to NHS 24 to help the service to increase its workforce as a result of the increased demand and changing service that it provides, including a new call centre in Dundee which opened in December 2021.

Next Steps

As we move into recovery, primary care services will focus on sustaining high quality services, supporting more integrated working with other health and social services, offering more care closer to people's homes and reducing health inequalities. We will do this through:

- Investing £170 million in 2022/23 to provide patients with easily accessible support from a wider range of healthcare professionals through their general practice such as pharmacists, community nurses and physiotherapists.
- Stepping down the COVID-19 Community Pathway from the end of March. Acknowledging the impact this will have on GP practice workload we will continue to support Practices as they manage acute COVID cases. For now, the GP Escalation Framework will remain in place and a further £15 million sustainability funding, announced in November 2021, will be made available this year
- Delivering up to £40 million a year for accessible mental health support directly through doctors' surgeries, providing support needed early and reducing specialist intervention later on.
- Taking further innovative action to prevent ill health in our most vulnerable citizens, flowing from advice of our primary care experts group on tackling health inequalities.
- Developing and introduce a new pharmacy woman's health and wellbeing service providing greater access to advice, guidance and treatments for conception, contraception and menopause.
- Investing upwards of a further £6 million to support patient access to dental services locally in 2022/23. We will also increase the ChildSmile in the community programme, providing an additional 41 Dental Health Support Workers nationally to support our work in minority ethnic communities.
- Delivering a more consistent model of NHS community eyecare and audiology services. This includes a National Community Glaucoma Service to safely manage lower risk glaucoma outside of hospitals, a National Low Vision Service, and Community Audiology Service to help ensure everyone can get the help they need to cope with sight and hearing loss when they need it. These services will be piloted in 2022/23 and fully rolled out over the course of this Parliament.
- The increase in NHS 24 staff will also help NHS 24 to play their part in the Redesign of Unscheduled Care. Currently, people who feel they may need to

attend A&E but whose condition is not immediately life threatening are being asked to use the 111 service.

- Supporting the Scottish Ambulance with their Demand and Capacity review. The investment of £20 million to support this will result in almost 300 new ambulance staff by April 2022, a mixture of paramedics, newly qualified paramedics (NQPs) and technicians. New and extra ambulances and associated vehicles will also be introduced in the coming months.

Mental Health

Progress

The past two years have tested the resilience of everyone in Scotland. There will have been very few of us who did not, at some stage, feel a strain on our mental health. It is crucial to understand that the mental health impacts of such a traumatic time will continue to emerge and evolve. The longer-term mental health effects will continue to be felt by many of us, across various levels of need. This will include mental ill-health in some cases.

Our [Transition and Recovery Plan](#) was published in October 2020 and set out our strategic response to the mental health effects of the pandemic. It contains over 100 specific actions, and is supported by a £120 million Recovery and Renewal Fund. This will transform services, with a renewed focus on prevention and early intervention.

The actions laid out in the Plan were based on data and evidence to help us identify where targeted action was required including:

- [The Institute for Fiscal Studies](#) (2020) reported that pre-pandemic there was an existing deterioration in population mental health and wellbeing, which is likely to continue as we learn to live alongside COVID-19.
- [The Scottish Mental Health Research Advisory Group](#) reported that one of the early impacts of COVID-19 was a higher level of distress. Over time, there is expected to be a worsening incidence of mental health disorders. Rates of traumatic reactions, substance misuse, self-harm and suicide are expected to increase.
- [Studies](#) have shown that there are groups in the population who are at higher risk of experiencing negative mental health impacts due to COVID-19. These include younger adults; women; those living on low incomes and individuals with pre-existing mental health conditions.

Our Scottish Mental Health Tracker Study has continued to monitor the mental health impacts of the pandemic.

Next Steps

In addition to the work we set out in the Transition and Recovery Plan, we acknowledge that there now needs to be an enhanced and specific focus on mental health as we move forward. In the next phase of our thinking about the harms that

have been caused by COVID-19, it is imperative that good mental health is seen a core part of recovery. We will specifically consider any potential impacts on mental health and wellbeing (both positive and negative) of any decisions we take as we adapt.

We will:

- Acknowledge the impact on mental health that has been, and continues to be, felt across Scotland.
- Ensure that improving mental health and wellbeing is an underpinning principle as we take strategic decisions.
- Ensure that evidence on the likely effects on mental health is specifically assessed as part of any future decision-making. The likely negative effects on mental health of any future protective measures will be weighed against the public health benefits of doing so.
- Ensure that face-to-face mental health services, including group therapy and emotional support, are able to continue, as fully as possible, under any future protective measures that are required. Subject to any measures required for the safety of participants, we want services to continue to be as adaptable and flexible to best meet people's needs.
- Continue to work closely with Health Boards to improve delivery of, and access to, services.
- Refresh our Mental Health Strategy during 2022, including a consolidated set of mental health commitments to reflect the current mental health and wellbeing needs of the people of Scotland. The new Strategy will be based on the latest data and evidence, and will include measures for helping individuals to thrive, as well as laying out how the system will respond whenever anyone asks for help for their mental health. This will ultimately ensure that people can access the right support, wherever and whenever they need it.
- Publish a new long-term Mental Health Workforce Plan to ensure we continue to grow and empower the workforce to respond to evolving need.
- Adapt and evolve our policy approach as the nature of the longer-term impacts on the mental health of the people of Scotland become clear. These impacts could include serious mental ill-health, however, earlier intervention is our opportunity to ensure this is not the case wherever possible.
- Ensure access to support for anyone experiencing periods of distress or crisis, as well as support for those with ongoing needs. Across our policies, we will focus on recovery and we will further embed trauma-informed approaches across all services and sectors (supported by our National Trauma Training Programme).
- Ensure our policy approach includes a strong focus on prevention and early intervention, so that the right help is available for anyone who needs it.
- Capitalise on the increased focus on mental health and wellbeing by promoting the importance of wellbeing, particularly in the community. This will include promoting self-help measures to help people build their own resilience and further expanding the help available in the community.

Bereavement and Loss

COVID-19 has taken a heavy toll of lives in Scotland, as it has across the world. In addition, during the height of the pandemic, the need to adopt COVID-19 protective measures denied countless friends and relations of those who died the opportunity to be with their loved ones at the end of their lives – whether caused by COVID-19 or other reasons. Traditional bereavement rituals have been interrupted and for many the grieving process has been protracted or intensified.

We must acknowledge the sacrifice and loss felt by so many and find ways to commemorate and to come to terms with our losses. We must also support those grieving and suffering continued emotional trauma as a result. We will look at factors leading to someone suffering prolonged, complex grief and, in collaboration with those with lived experience, ensure the right help and support is available.

For example, the Community Memorials Project, with £4.1 million support from the Scottish Government and administered by Greenspace Scotland, will enable communities to remember in their own way. Communities will be supported by artists to develop projects that help them reflect on the impact of the pandemic. Greenspace Scotland commissioned artists will engage with community groups, faith groups and those hit hardest by the pandemic to shape ideas that benefit communities and reflect local people's experiences of the pandemic.

Social Care Resilience

Throughout the pandemic social care has been under significant pressure and the position across Scotland has been changing rapidly due to staff absences (not all COVID-related), COVID-19 outbreaks in care homes and demand for care.

Progress

As an immediate response, partnerships redeployed staff to ensure safe care within care homes and other services and all partnerships instigated some level of business continuity plans due to substantial and escalating service challenges, prioritising care for those most in need.

All partnerships have made significant efforts to secure additional staff with the appropriate skills and capability to provide the right support for people. A range of short-term actions were taken to cover the festive period, identifying additional staff with existing care or nursing qualifications. Training has also been provided rapidly to give wider staff groups basic skills to enable them to contribute. In the medium term, the priority is to support the ongoing task of recruiting and retaining more care staff at all levels.

In response to these pressures the Scottish Government has announced £300 million in additional funding as part of measures put in place to support current system pressures in the social care sector. The aim of this new investment is to maximise capacity, ensuring flow through the system, and caring for our staff. This included: £40 million for 'step-down' care, so that hospital patients can temporarily go into care homes, or can receive additional care at home support; £62 million to

maximise the capacity of care at home services; up to £48 million to increase the hourly rate of frontline social care staff; and £20 million to enhance multi-disciplinary teams, so that more social work assessments can be carried out, and to support joint working between health and social care.

One of our priorities for social care is improving Fair Work practices, to help to retain and attract more workers into the sector, which builds a more stable, resilient and experienced workforce. We are committed to improving the experience of the social care workforce, including increasing levels of pay, which we know is crucial to addressing long standing recruitment issues in the sector. The Fair Work in Social Care Group has also developed a set of recommendations for minimum standards for terms and conditions reflecting Fair Work principles. This extends to the development of local standards that employees should expect. This work is now being taken forward. We are also working with key partners to promote career opportunities and pathways within social care, upskilling and developing the workforce in order to address retention issues and to attract new people to the sector as a rewarding career choice.

Next Steps

We are developing solutions to further ease the pressure across the social care system, including additional support for unpaid carers and those for whom they care. We are encouraging local authorities to make full use of the flexibility offered through Self-Directed Support (SDS), in particular so that family members and friends can be employed as personal assistants by people in receipt of SDS. This has been an important way for people to ensure they have support that suits their needs. Employing family members or friends is some people's preference, and we are considering ways to better enable this in the long term.

As a short-term measure, we are working with local authorities to encourage the provision of support prior to an assessment being carried out. Pressure across the system has meant that people have sometimes had to wait for their support needs to be assessed. Using existing powers in the Social Work (Scotland) Act 1968, if a local authority considers that there is an urgent need for support, it may provide this support before carrying out an assessment. Where it is appropriate to do this, it will allow people to receive support more quickly than might otherwise be possible.

Where support is provided in this way, it is a legal requirement to undertake an assessment as soon as practicable thereafter. Various statutory safeguards exist to protect those in receipt of SDS, and any family members who may be asked to provide support in this way. The safety of the person in receipt of support remains paramount, and social workers and other relevant practitioners will use their professional judgement to identify the most appropriate mechanism to support an individual.

Both of these approaches should help ease the burden on people who receive support and on the system itself by enabling greater flexibility in the provision of support and care.

Resilient Communities

The capability, strength and kindness of individuals, communities and third sector organisations are an essential part of Scotland's resilience to major challenges. From the earliest days of the COVID-19 pandemic it was clear that what individuals, communities and the organisations working with them were achieving together made a significant and very meaningful contribution to the response to the pandemic. We, alongside our partners across Local Government, are committed to supporting this resilience by providing necessary support and advice, and enhancing the integration of the third sector with resilience structures and processes.

Progress

Collaboration on the COVID-19 response has cemented many local relationships and connections and stimulated new ones, at community level. It has been a striking feature of the COVID-19 response that significant support has been largely from locally focused third sector groups, staff and volunteers. There has been a period of rapid learning, creativity and adaptation as people have stepped outside their usual ways of working. This has created important shifts in mind-sets and enabled a broader understanding of resilience to encompass wellbeing as key considerations alongside the economy.

The National Volunteer Coordination Hub (NVC Hub) was set up in February 2021 to provide additional volunteers for the COVID-19 vaccination and community testing programmes. It offers a single national point of contact which complements local arrangements and supports Health Boards where sufficient volunteer capacity is unavailable. It is operated by the British Red Cross, and draws on the volunteer resources of a range of third sector organisations. The Hub model has contributed over 54,500 volunteer hours of support to the range of COVID-19 response programmes across Scotland. The NVC Hub was set up as a short-term arrangement but due to its success is being extended.

Next Steps

The Ready Scotland website will continue to provide practical advice and guidance on how individuals and community groups might continue to support people within their local communities who may need practical assistance owing to COVID-19 variants and outbreaks, and enable those who wish to continue the community groups formed in response to COVID-19 to support any future response.

We will work with partners, across civic society, including our partners in Local Government, to further develop the NVC Hub users' requirements in the longer term and put sustainable arrangements in place to help meet demand for volunteer resources in future national emergencies.

Supporting Families, Babies, Children and Young People

Progress

There has been a lot to learn during this pandemic about the pressures on families, including families where the parents are no longer together. It has underlined the critical value of a holistic, whole-family approach to support, which is rooted in the community and driven by the voices and needs of babies, children and their families.

New and existing inequalities have emerged or been exacerbated, making the lives of many of the youngest in our society even harder and providing less opportunity for them to reach their full potential. Uncertainty and complexity have run through this pandemic. We will seek to reduce this uncertainty, and act to reduce complexity and help families, babies, children and young people access the help they need, how and where they need it.

Preventing further harm to current and future generations must shape our current and future responses, beginning in the earliest years of life. We know the significant pressures that the pandemic has placed on families, and we will be proactive in building multi-disciplinary and multi-agency family support services which enable families to thrive.

At the start of the pandemic, a Collective Leadership Group was formed, with partners from across agencies and the third sector to act rapidly on what was required to be in place to meet the needs of babies and children with the highest level of vulnerability. This group continues to help shape and inform the national and local responses, providing valuable local insight and challenge to inform national planning.

In learning the lessons from recent experience we will ensure that the rights of all children are aligned to what will help them grow and thrive and minimise periods where children's rights are restricted. Including children and young people in decision-making is the best way to ensure responses and adaptations are more likely to meet their needs.

We will continue to review the guidance for all services that support pregnant women, babies, children, young people and families, to reduce the risk of transmission of the virus, alongside balancing the risk of harm to children by becoming 'invisible' to services during periods of restriction. This should include prioritising face-to-face visits, in the home, wherever possible.

We will continue to review the evidence of the impact of the pandemic and the response, prioritising action to support those with additional needs and vulnerabilities to prevent further marginalisation from society. This will include considering the role of the COVID-19 Collective Leadership Group to shape our overall response, alongside other partners, including the NHS.

Lessons learned highlighted the importance of maintaining direct contact with children, young people and their families, through established trusted relationships, to ensure early offers of support are facilitated.

We remain committed to improving the journey of children and young people through the care system. We will continue to support the invaluable work of the Scottish Children's Reporter Administration (SCRA) and Children's Hearings Scotland (CHS) to deliver children's hearings as recovery from the pandemic continues.

Next Steps

We are:

- Investing at least £500 million over the life of this Parliament in Whole Family Wellbeing Funding, to provide whole family support and act as a transformation fund to shift from chronic to preventative interventions as we #KeepThePromise.
- Publishing a Promise Strategic Implementation Plan, by the end of this Parliamentary year at the latest, that sets out the commitments and actions that we will take as Government to Keep the Promise.
- Working to deliver refreshed GIRFEC (Getting it right for every child) policy and practice guidance in partnership with key delivery partners across all sectors. Refreshed materials aim to provide practitioners with the confidence, clarity and practical support to continue to implement GIRFEC which lies at the heart of all our policies and services to support children, young people and families and plays a central role in achieving our collective ambition for Scotland to be the best place to grow up.
- We will publish our next Tackling Child Poverty Delivery Plan in March 2022 which will outline the transformational actions we will take alongside partners to tackle and reduce child poverty in Scotland, in line with the ambitious targets set by the Child Poverty (Scotland) Act 2017.

Early Learning and Childcare (ELC)

Progress

We have supported the Early Learning and Childcare (ELC) and school-age childcare sectors to continue to provide high-quality and nurturing services to children and their families during the pandemic. Key actions we have taken include:

- Working with local partners to successfully implement the expansion of funded ELC from August 2021 despite the challenges of the pandemic, almost doubling the entitlement of all 3 and 4-year-olds and eligible 2-year-olds to 1,140 hours.
- Making up to £35 million of dedicated financial support available to childcare services since the start of the pandemic. On 10 February 2022, the Scottish Government announced a new Childcare Sector Omicron Impacts Fund, which will in total make up to £9.8 million available to provide one-off grants to the childcare sector this financial year.
- On 4 December 2020 we confirmed that qualifying day nurseries will continue to benefit from 100% relief on non-domestic rates until at least June 2023, worth on average £12,000 to each eligible setting.

- Working to roll out the vaccine: coverage of the vaccine is now very high, with rates of uptake of doses 1 and 2 among childcare staff comparable to the general population. Work is taking place to increase uptake of the booster in order to provide maximum protection to everyone working across the childcare sector.

Our ambition for ELC is to deliver the best possible outcomes for children, parents and families by helping to close the poverty-related attainment gap, increasing family resilience through improved health and wellbeing of children and parents, and creating opportunities for parents to access work, study or training.

ELC settings provide an essential service to children and families and are vital in supporting children's learning and development. The context for delivering ELC has changed significantly since March 2020. The work of staff across the sector to deliver care for children over the pandemic has been extraordinary. Despite best efforts, the latest data show that the society-wide protective measures that have been necessary have affected young children's relationships and development, with children from low-income families being more negatively impacted.

Next Steps

Our key strategic aims over the next 12 months are:

- Continued commitment to working in partnership with Local Government and other partners to prioritise children's outcomes and deliver the right balance of specific measures, ensuring a continuing focus on priority groups.
- Re-focusing efforts on sectoral resilience and proofing against pandemic and other shocks, to keep staff, children and families safe across local communities.
- A focus on recovery to support the sector to address the impacts of COVID-19 on children and families, working with partners in Local Government, and wider society.

We will work with our partners in the childcare sector, child contact centres, public health, local government and the regulatory bodies to learn lessons from the experiences of 2020-2022 and agree the principles that will govern our management of the endemic phase and any future public health emergencies.

Building on our established childcare sector Financial Sustainability Health Check and ongoing engagement, we will continue to assess the financial impacts of the pandemic and take further steps to support the long-term sustainability of all parts of the childcare sector. We will work with local government to embed COVID-19 recovery in spending plans for 2022-23 through the specific grant funding for 1,140 hours and the forthcoming Resource Spending Review.

Through the development of our 5-year Childcare Workforce Strategy, to be published later this year, we will work with the sector and skills bodies to support the current and future workforce to deliver high-quality care and learning in a safe and sensitive way, mindful of the impacts of the pandemic. In taking this forward, we will enable the childcare workforce to access professional learning resources and specialist services that will support them as they work with children and families

through our recovery from the pandemic. We will also increase support and resources for staff wellbeing by further developing the Team ELC Wellbeing Hub. In order to ensure additional resilience across the system, we will work with Education Scotland on further development of learning-at-home resources which can be used by staff supporting children who are unable to attend settings and we will work with Parent Club on additional resources and advice for parents.

We will simplify and streamline the suite of COVID-19 guidance for ELC settings, school-age childcare and childminding services to enable a more 'normal' ELC experience for staff, children and families as the virus becomes endemic. This will include work to support practitioners to maximise the use of outdoor space and to increase the amount of time children spend outdoors every day, learning from the experience of the pandemic.

In addition to the Childcare Sector Omicron Impacts Fund, ELC settings will be able to benefit from additional funding of £5 million, which is being made available to make sure ventilation is as effective as possible.

Schools

Progress

In line with advice from the WHO and elsewhere, one of our top priorities has been, and will remain, to keep early learning and childcare (ELC) settings and schools open and safe, and to ensure continuity of the care, education and support they provide to children, families and communities.

Our [Reducing Risks in Schools Guidance](#) and COVID-19 safety guidance for ELC settings, [school-aged childcare](#) and [childminding services](#) set out the protections that local authorities, schools and settings should ensure are in place. Those protections are kept under close review based on advice from the Advisory Sub-Group on Education and Children's Issues, through consultation with the COVID-19 Education Recovery Group (CERG) and other stakeholder groups.

We will continue to review that guidance, and the measures set out within it, to ensure that they support a strategic move over time to managing rather than suppressing the virus, and that they support the best possible outcomes for children. Appropriate and proportionate protective measures – aligned with those across society given the determined level of risk at any stage - will continue to be required to manage the virus. We will engage closely with public health experts, staff, parents and representative bodies in determining those measures and to minimise the operational and educational impacts, while keeping children and staff safe.

Good ventilation remains important in controlling the spread of COVID-19 so our guidance sets out how to ensure a balance between fresh air and warmth. Up to £5 million is being made available to support local authorities to make sure ventilation is as effective as possible, and that any urgent remedial action is undertaken in schools and ELC settings. This is on top of a previous £100 million of COVID-19 logistics funding - £10 million of which was specifically for ventilation and

CO₂ monitoring to complete initial assessments of all learning, teaching and play spaces.

Next Steps

Our ambition for education in Scotland remains to deliver excellence and equity for all, with health and wellbeing at the forefront of our plans. This builds on the previous recommendation of our International Council for Education Advisers to work towards a 'pandemic-proof' education system.

Our document [Education Recovery: Key Actions and Next Steps](#) included a number of actions that will help to turn this aspiration into a reality. For example, in 2022-23 we will commence preparatory work to ready the school estate and the people in it for an influx of new technology from 2023-24 onwards, leading to a fully digitally enabled education system by the end of this Parliament.

Alongside this, based on feedback and learning, we continue to make improvements to Glow services as well as to evolve and improve the National e-Learning Offer (NeLO) to make sure it best supports the changing needs of schools and learners as the pandemic conditions change.

Practitioners are currently supported in the pedagogical and technical use of digital technology for face-to-face, blended and remote learning through a range of professional learning and leadership opportunities provided by Education Scotland.

Since the start of the pandemic we have taken action to ensure additional teachers and support staff are in the system to aid education recovery. We have provided additional funding of £240 million for these staff and school census data show that we now have over 2,000 more teachers in the system than before the pandemic.

This injection of additional resource is providing vital additional support to the education system when it is most needed. Our commitment to increase teacher numbers by 3,500 over the course of this Parliament will ensure that capacity and resilience in the system continues to build over the coming years.

The wellbeing of all children and young people has been a central focus of our response to date. We will work closely with key stakeholders to agree future priorities that will ensure we build on the work already undertaken to ensure children and young people get the right support at the right time, with an updated [Additional Support for Learning action plan](#) to be published in spring 2022.

We continue to support our local authority partners with £16 million in funding to ensure that every secondary school has access to counselling services. Our online professional learning resource supports school staff to understand and recognise the range of mental health and wellbeing concerns young people may experience. We have also introduced new guidance to support whole-school approaches to mental health and wellbeing, complementing the work that education authorities and schools already do to support children and young people's mental health and wellbeing. We will continue to work with the Mental Health in Schools Working Group to embed these approaches across Scotland.

We have already invested over £2 million in supporting teacher wellbeing. Support is also available for those in leadership roles which focuses on looking after their own mental health as well as the mental health and wellbeing of their teams. We intend to offer a similar package of wellbeing professional learning to the education workforce going forward, and are working with partners to progress that.

We have continued to prioritise the support of children and young people who need it most, including through an investment of £1 billion to support education recovery and tackle the poverty-related attainment gap. In recognition of the impact of both the pandemic and poverty across Scotland, the refreshed Scottish Attainment Challenge programme will see funding reach all 32 local authorities, with a framework for recovery and accelerating progress, being developed with the system, to support greater progress in tackling the poverty-related attainment gap and improve outcomes for children and young people impacted by poverty.

In addition, we will continue to take forward recent Organisation for Economic Co-operation and Development recommendations, including considering the outcomes of the reform work being undertaken by Professor Muir and the work of Professor Hayward on the assessment and qualifications system. Any major reform of the qualifications system will require careful consideration and will take time to develop and fully implement.

It is our firm intention that exams take place this year, with contingencies for any further disruption. Results for the 2022 National Qualifications will be published on 9 August. Decisions on the approach to the 2023 National Qualifications will be informed by public health advice at the time, and by the views of stakeholders.

Colleges, Universities and Community Learning and Development

Progress

We recognise the impact of COVID-19 on students and staff and continue to work collaboratively with universities, colleges, Community Learning and Development (CLD) providers, trades unions and student representatives, and on the basis of input from the COVID-19 Expert Advisory Sub-Group on Universities and Colleges, to provide support and to develop sector guidance. This has enabled the safe resumption of in-person teaching.

Our financial support to students during the pandemic has been substantial. Over £96 million has been provided via hardship funding, digital access support, mental health support and for student associations. This funding has included:

- A £5 million Digital Inclusion Fund, which was provided to support over 13,500 post-school learners access online learning.
- For mental health, £4.2 million funding has been allocated for the 2021-22 academic year, a £0.6 million increase from 2020-21. In addition, £4.4 million was announced to help college students and staff respond to the pandemic.

We continue to urge students experiencing financial hardship to apply to their college or university for support from the Further or Higher Education Discretionary Funds.

Next Steps

Over the past two years, in-person teaching and learning has been severely restricted and we recognise the harmful impact that will have had on students, staff and society more generally.

Our strategic aims in the weeks and months ahead are:

- To work with colleges, universities, CLD providers and wider stakeholders to manage COVID-19 effectively, and in line with the Scottish Government's overall Strategic Intent, in order to ensure that in-person teaching is the appropriate and desirable position for most courses;
- To work with stakeholders in order to address the impacts of the accumulated wider harms and lost learning on students and learners.

On the basis of advice from the COVID-19 Advisory Sub-Group on Universities and Colleges, we will work with our partners on the Advanced Learning COVID-19 Recovery Group – Chaired by the Minister for Higher Education, Further Education, Youth Employment and Training – to develop a framework, to replace prescriptive sector-specific guidance. This will enable decisions on COVID-safety protocols and measures, beyond any that may be in place across society, to be determined locally and, where possible, collectively. The focus of this framework will be to monitor the wider pandemic context and potential implications for the sectors; provide information, high-level guiding principles and support for the sectors; and to allow local solutions tailored to particular needs and circumstances.

As part of this approach to managing the virus, we will work with universities and colleges to support the development of institution-level COVID-19 Response Committees, where possible retaining existing structures put in place over the pandemic. The Committees – comprising representatives from the institution, trade unions, student bodies and providers of purpose-built student accommodation – will monitor public health advice and the wider context, with a view to adjusting institution safety protocols accordingly. We will work with the Committees to consider appropriate surveillance and monitoring methods.

We will work also with universities, colleges and CLD providers to ensure good ventilation is a key focus across their estates and the buildings they use.

The COVID-19 Advisory Sub-Group on Universities and Colleges has focused much of its work since the start of this academic year on the impact of the pandemic on the wider harms and lost learning on students. Over the next 12 months we will continue to consider these impacts as work intensifies across the Scottish Government on recovery from the pandemic.

We will also work with institutions, the Scottish Qualifications Agency and other professional accreditation bodies to pursue sustainable, alternative approaches to assessment/accreditation which can be used should the public health situation require it.

Housing

The pandemic has underlined the importance of home as a place of safety and of housing for health outcomes more generally. It is important that essential housing services to tenants such as repairs, maintenance, allocations and lettings, dealing with anti-social behaviour, domestic abuse and housing management issues, tenancy sustainment and homelessness prevention work all continue.

Progress

Guidance on the effective provision of housing support and services in the context of COVID-19 has been made available in partnership with the housing sector and frequently updated. This draws on learning from the experience of the pandemic about how to support essential works in homes in a way that keeps staff and tenants safe.

We remain fully aware of the financial difficulties facing many people as a result of the pandemic, and are doing all we can to support them. We have made clear since the outset that taking eviction action against those who have suffered financial hardship should be an absolute last resort, and have put legislation in place requiring private landlords to work with their tenants to manage rent arrears before seeking eviction. Emergency legislation temporarily extended the notice period a landlord must give, and to enabled the Housing and Property Chamber of the First Tier Tribunal for Scotland to take all the circumstances into account in repossession cases and introduced private landlord pre-action protocols (these set out the steps a landlord should take to support a tenant in rent arrears before commencing eviction action). This legislation is currently in place until 31 March 2022 and the Government will shortly confirm its position on extension of provisions to 30 September 2022.

Next Steps

The Coronavirus (Recovery and Reform) (Scotland) Bill sets out our intention to implement both private landlord pre-action protocols and Tribunal discretion on a permanent basis, helping to support the private rental sector in its recovery from the pandemic. We have also provided support totalling £39 million to tenants during the pandemic, including a £10 million Tenant Grant Fund for people at risk of homelessness because of changes to their finances, and money for discretionary housing payments to those needing help with housing costs.

The pandemic has shown what is possible when we work collectively and has increased our determination to end homelessness and rough sleeping. From the outset we worked in partnership with local authorities and the third sector to ensure everyone had a safe place to stay, and the number of people sleeping rough in our cities remains low. Building on our updated Ending Homelessness Together action plan, we are committed to continued action and partnership working to ensure nobody returns to rough sleeping. People with no recourse to public funds will be particularly vulnerable to homelessness when public health requirements change. We will continue to work collaboratively with COSLA to provide local authorities with

clarity on their duties and with the third sector to develop a cohesive approach to support those most at need.

We will work with frontline homelessness organisations to continue to explore creative solutions that help people who are homeless or rough sleeping to access vaccinations. We will build on the success of previous initiatives, which included flexible vaccination appointments, drop-in clinics and on-site vaccinations being made available in temporary accommodation locations. We will continue to fund local authorities' Rapid Rehousing Transition Plans (RRTPs) and have committed to further funding for 2022/23 and 2023/24 to enable local authorities to plan over a two-year period. This will encourage a continued housing-led approach to addressing homelessness.

In addition we are currently reviewing the [COVID-19 framework to support Gypsy/Traveller communities](#). Gypsy/Travellers face additional risks and vulnerabilities during the COVID-19 pandemic and living situations may make it difficult for them to limit virus spread and comply with public health guidelines. As we move to a more sustainable level of support, there is an opportunity to embed approaches which would allow Gypsy/Traveller communities to follow public health advice and more easily access the facilities and services that they need.

Transport

Progress

Since the beginning of the pandemic we have taken actions to ensure our operators and delivery partners have continued to provide a safe and reliable transport system for those using our transport network. We have provided over £1 billion since the start of the pandemic to support transport operators to maintain essential services for those who rely upon them. We have also:

- Provided up-to-date guidance for those who operate and use our transport networks;
- Monitored and assessed the demand for travel, in order to support the evidence to adapt the transport system;
- Assessed the COVID-19 transport impacts and measures, including changes to economic and social activity, and subsequent travel demand; and
- Engaged extensively with operators, stakeholders and delivery partners (transport operators, COSLA, regional transport partnerships, poverty groups, the Mobility and Access Committee for Scotland, business umbrella groups and academics) to work collaboratively on our response to COVID-19.

Next Steps

We are now taking forward a broad package of work to ensure that there is a viable and sustainable transport system for the future. As part of this we are developing work to facilitate a safe and confident return to public transport as more people begin to travel between their home and their place of work and as demand for leisure travel also increases. We are:

- Undertaking activities to promote a safe and confident return to public transport;
- Updating operator and passenger guidance to support safe provision and use of public transport services;
- Engaging with operators and delivery partners to promote safe behaviours and the measures required to support our recovery from COVID-19; and
- Monitoring and assessing travel demand and identifying evidence of changes to travel behaviours and public transport demand that have become embedded due to COVID-19.

Justice

Progress

Across the wider justice system, we recognise the operational and service delivery challenges posed by the pandemic, which has had considerable impacts for justice agencies and third sector organisations who play a critical role in supporting those who engage with the justice system. As the criminal justice system recovers from the pandemic, we aim to build a justice system that is fit for the future and build on work already undertaken under the umbrella of the Recover, Renew, Transform Programme to support recovery and reform of the justice system.

Next Steps

The Scottish Government continues to support justice agencies to take action to address the backlog caused by the pandemic. In our January 2022 budget statement we announced significant funding increases for the justice portfolio - funding that is required to deal with the backlog. We have established a justice recovery fund of £53.2 million in the next financial year to be allocated to recovery, renewal and transformation activity across the justice system as we emerge from the pandemic. This will include funding of £26.5 million to the Scottish Courts and Tribunals Service to maintain enhanced court capacity and remote jury centres.

We have previously committed an additional £50 million in 2021-22 to support our Recover, Renew, Transform Programme for the criminal justice system – which has included setting up 16 additional solemn and summary courts from September 2021. The additional £50 million is being used in a variety of ways to increase capacity across the justice system, including the recruitment of additional staff, greater use of digital tools for criminal, civil and administrative justice activity and improved support for victims and witnesses. We recognise the harm caused to victims, witnesses and those accused of crime by delays within the justice system. Justice agencies have been clear that the recovery programme will take several years to address the backlog and we will continue to support that work.

The Coronavirus (Recovery and Reform) (Scotland) Bill will continue certain temporary justice system provisions on a longer extension basis as part of the Recover, Renew, Transform Programme and as a response to the impact of COVID-19 on the justice system, particularly where backlogs have unavoidably built up.

The Scottish Prison Service has, in line with Scottish Government guidelines, gradually and cautiously lifted regime protective measures that were necessary to protect the health and wellbeing of those who live and work in our prisons. A Restoration of Services project supported establishments to return to pre-pandemic regimes by the end of September 2021. Measures remain in place to allow for regime changes where this is deemed necessary in an outbreak situation. The Scottish Prison Service continues to work collaboratively with all health boards to maximise opportunities for providing vaccinations to those in their care. From 26 April 2021, it has enabled greater access to in-person visits in establishments with robust local risk assessments in place and implementation of protective measures for staff, prisoners and visitors. In-person visit provision has continued, and has only been affected when there has been a localised outbreak.

Looking Forward

This update to our COVID-19: Strategic Framework has set out our progress and plans for managing the epidemic as it hopefully enters a calmer phase.

Omicron has provided us – and countries across the world – with a salutary reminder that the virus will continue to evolve into new variants, some of which may be more harmful. And while we can look forward with a higher degree of optimism than at any point previously in the pandemic, as our economy and broader society continues to recover from the experience of the past two years, that optimism must be tempered by vigilance and preparedness for what lies ahead.

We must all continue to do everything required to remain resilient and to keep the virus in check. Our lives will not go back to exactly as they were before COVID-19 and, indeed, there are some aspects of life during the pandemic that we would want to hold on to – that could serve us well for the future.

This approach will be consistent with our strategic intent, which has been updated for the next phase of the epidemic: to manage the virus effectively, primarily through adaptation and health measures – such as vaccination, treatment and surveillance – as we recover and rebuild for a better future. As part of our approach we will ensure that the guidance on what we need to do remains clear.

This Strategic Framework has set out what we all must do as we come to rely much more on positive behaviours and actions to manage COVID-19 effectively and sustainably, and much less on legal requirements and restrictions on our way of life. However, should the virus yet again pose an acute threat to our health, we have set out how we plan to respond effectively and proportionately, to enable people and organisations to plan for the future with greater confidence.

We have set out not just the progress we have been making, collectively, across the many fronts of managing the epidemic in Scotland, but also the actions and activity that we plan to take going forward, following engagement with stakeholders. This reflects the focus that we continue to place on the effective management of COVID-19, and on paving the way for future recovery as set out in our [COVID-19 Recovery Strategy](#), which continues to progress at pace. And we will play our part in ensuring that effective management of COVID-19 is shared across the world.

As we look forward, we will not forget all those who have been tragically lost to this virus nor the many struggles and sacrifices that we have endured together, and that many people and organisations continue to endure. In particular we must continue to support those who remain at heightened risk from COVID-19.

And we will support the work of the COVID-19 public inquiry in Scotland alongside that of the UK public inquiry. We will listen to the developing lessons and research that can help us to navigate through future pandemics and other emergencies better.



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Test and Protect Transition Plan

March 2022



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Test and Protect Transition Plan

Test and Protect has been one of the key interventions over the course of the last two years in Scotland to reduce the impact of COVID-19 on our health, and on the wider social and economic harms caused by the pandemic. The primary goal of Test and Protect has been to reduce population wide transmission of the virus. Through providing access to the whole population to widespread testing, population level contact tracing, and financial and practical support for isolation, Test & Protect has broken chains of transmission and saved lives.

This intervention has only been possible thanks to a dedicated workforce across testing, contact tracing, and supporting isolation; and significant, sustained and committed engagement by the public in coming forward to be tested if unwell, taking part in asymptomatic testing at peak times of risk, and following the advice given to isolate to avoid further transmission of the virus.

As we set out in our updated *Strategic Framework* in February, we now recognise we are in a different phase of the pandemic. As we see the prospect of transitioning to the virus becoming endemic, the impact of vaccination and treatment options on severe disease, and the wider harms of a strategy overly focussed on suppression at this point in time, our Strategic Intent is now:

To manage COVID-19 effectively, primarily through adaptations and health measures that strengthen our resilience and recovery, as we rebuild for a better future.

At the beginning of the pandemic – before we had the benefit of vaccinations and treatments – large scale infrastructure to test, trace and isolate on a population wide scale was required to reduce transmission, as were other widespread protective measures. We are now in a very different position with population levels of immunity and new treatments significantly reducing the direct harms of the virus.

The purpose of testing at this phase in the pandemic is changing.

The primary purpose of testing is changing from population wide testing to reduce transmission to targeted testing to support clinical care. Testing will also still be required for other purposes too – it will play an ongoing role in health and care workforces, given the clinical risk in those settings, and will be a key part of surveillance. We know too that we continue to face Covid risks – including of new, more harmful variants. Contingency to respond to those risks will, at times, include additional testing.

This means our strategic intent for testing is changing too. It is now:

To adapt Test & Protect to support the effective management of COVID-19 as it becomes endemic, to support patient treatment and care; protect those in highest risk settings; monitor prevalence and the risk of new variants, respond to outbreaks, scale if required for future health threats, and build a legacy for wider population health benefit.

However, we intend to move to this new approach to testing in a phased way. Subject to the phasing set out below, we are advising people to continue to test on the same basis as now - for those without symptoms this means testing with lateral flow devices twice weekly and daily for 7 days if you are a fully vaccinated close contact of a positive case. For those with symptoms, it means getting a PCR test.

From Easter onwards, we will begin the transition towards our targeted approach - which we are describing as 'steady state'. Test sites will remain operational until the end of April. However, to support the transition there may be some changes to opening hours and locations of test sites during April. It is important to note that testing will always be available if advised as part of your clinical care.

For any purpose for which testing (PCR or lateral flow) continues to be advised, we will ensure that these remain available free of charge.

After Easter, the key steps will be:

Step 1: From Mid April – (for most people) if you are well, with no symptoms, you will no longer be advised to test twice weekly

- Advice to the general public to routinely test if asymptomatic will cease and access to lateral flow tests for that purpose will stop.
- Routine asymptomatic testing in workplaces will cease (with the exception of health and social care settings).
- Routine asymptomatic testing in education settings – schools, early learning and childcare, and universities – will cease at the end of the current term.

However...

- PCR tests will remain in place for anyone with symptoms with tests accessible at test sites and by post.
- Contact tracing and support for isolation continues.
- Positive cases will continue to be advised to isolate (though can continue to shorten their isolation period if negative on lateral flow tests on day 6 and day 7).
- Fully vaccinated close contacts will continue to be advised to test daily for 7 days.
- Anyone visiting a care home or hospital will be asked to do a lateral flow test in advance.

Step 2: From End April - Transition to steady state - move from population symptomatic testing to testing for clinical care, surveillance and outbreak response

- Move from population level symptomatic testing to targeted testing for clinical care.
- Groups eligible for testing to support clinical care will access tests through the home order channel.

- General public will no longer be advised to seek a test if symptomatic – at this stage we will move instead to general public health guidance to stay at home if unwell.
- Test sites will close at the end of April.
- Population level contact tracing, isolation and support will end and we will stop using the Protect Scotland proximity contact tracing app (but retain it for future use if required).
- Surveillance and contingency infrastructure for outbreak response will remain in place.
- Ongoing routine asymptomatic testing in health and social care workforces will continue – with this kept under regular clinical review.
- Anyone visiting a care home or hospital will still be advised to do a lateral flow test in advance - though this will be kept under regular clinical review.

A timeline of the key changes as part of the transition are included at Annex A.

Testing Steady State

At the end of the transition period (from beginning of May) we will move to a new steady state for Test and Protect. This will be built around six pillars and be supported by ongoing investment in testing as part of the required health measures for the effective ongoing management of COVID-19.

Testing for clinical care

As with all diseases, the effective clinical care of a person with COVID-19 will sometimes require testing to confirm or rule out diagnosis. Those who are eligible for anti-viral treatments now, and for those future treatments in development, will continue to be able to access testing – in the community and in hospital settings. In addition, testing may continue to be recommended in advance of certain other clinical procedures – such as pre-operative testing – in order to improve patient outcomes. Testing like this if advised as part of your clinical care will always be free at the point of need – as with all of our NHS.

Evidence on which groups of people can benefit from, and are therefore eligible for, antiviral treatment continues to build and to be reviewed. We will always ensure testing is available to help people get the treatment they need. The current route for people across the UK to access testing for the purpose of accessing antiviral treatment is the home order channel for both LFD and for follow up PCR. This route will remain the key route for access for those in the community, with tests for those in hospital arranged by clinicians in the usual way and processed in our NHS Scotland laboratories.

Testing to protect those in highest risk settings

Some regular asymptomatic testing – for example in health and social care workforces – will continue to be in place, alongside a range of other infection prevention and control measures such as PPE, in order to reduce the risk of the spread of infection in settings where the clinical risks of transmission are high.

Precise advice for different workforce groups within the broad category of health and social care will continue to evolve, based on clinical advice. For many groups, the advice will be to continue to test twice weekly with LFD tests. In general in social care, the priority will continue to be testing in long stay settings for elderly people such as residential care homes. There will also be a continuing priority in health care worker testing to support testing for hospital based staff to reduce the risk of infection spread in our hospitals.

Similarly, there will be continued access for testing to support care home and hospital visiting, subject to regular clinical review and advice.

Surveillance

Not all surveillance requires testing – much of the long running respiratory surveillance systems in Scotland, both in the community and in hospitals, relies on a range of measures including data from GP systems and NHS24, monitoring trends at

a population level in the reporting of certain symptoms, and monitoring disease severity and patient outcomes in hospital settings.

However, testing will remain a critical part of enhancing this existing surveillance, to best adapt to the additional requirements of effectively monitoring COVID-19 trends and new variants. This includes ongoing random sample PCR testing through the ONS Community Infection Study, wastewater testing, and genomic sequencing to investigate variants of interest and concern when they arise. A proportion of regular testing carried out for clinical care purposes – for example, hospital based PCR testing, will also routinely be sequenced, enabling a further layer of surveillance for any emerging signals of new variants of concern.

Outbreak response

At times, in particular as part of the investigation of potential new variants, testing will be part of the regular Health Protection led response to outbreaks of respiratory disease – which will include COVID-19 outbreaks – in settings. Public Health Scotland are leading on the key guidance to local Health Protection teams on investigating new variants of concern – the Variants and Mutations Plan – which includes clear processes on testing and contact tracing as part of outbreak investigation and response.

Contingency

The ability to respond in the event of new variants requires contingency to be maintained across Test and Protect capabilities. This includes a core contingency of LFD stocks, Mobile Testing Units, PCR testing capacity and the ability to rapidly sequence positive tests, and enhanced Health Protection teams in local Health Boards with retained skills in complex outbreak investigation and support from PHS experts in epidemiology.

Sufficient LFD stocks will be held in contingency in Scotland to enable a rapid increase in the intensity of targeted testing if required in the event of a new variant of concern. This contingency would assist in adding to layers of protection that may

need to be enhanced, in particular around high risk closed settings. Contingency stocks will be sufficient to enable two months of additional enhanced testing, which also enables time to procure additional testing if required. In addition, to support the investigation of new variants, a contingency fleet of ten Mobile Testing Units will be maintained, and ongoing access to a reduced UK wide network of PCR testing will be retained.

We will also keep the daily case rates, hospital data and other key indicators under close review over the transition period and retain the option – subject to clinical advice – of being able extending symptomatic testing beyond the end of April (using lateral flow tests) if the pandemic circumstances require this.

Legacy

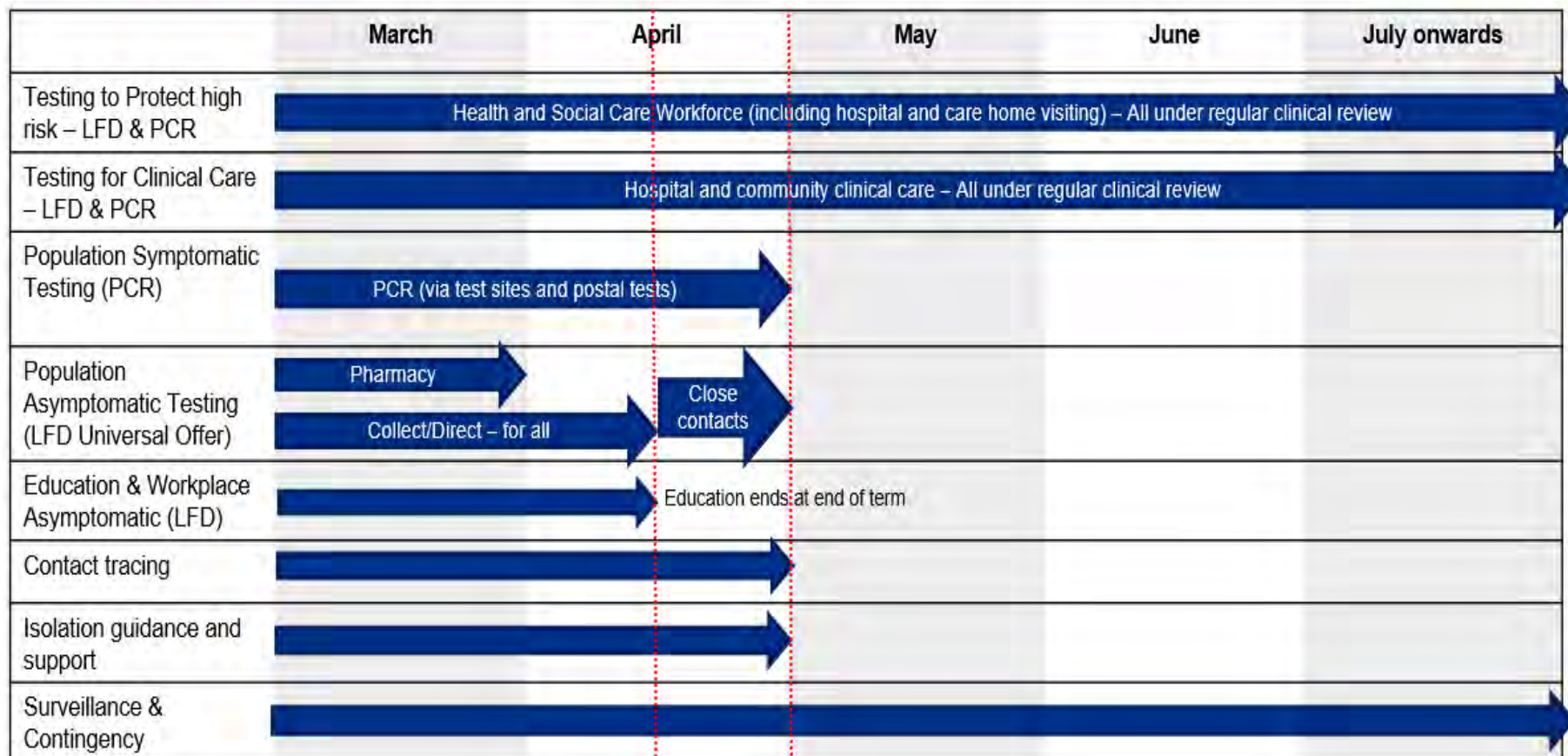
In the two years since the pandemic started Scotland has invested significantly in diagnostics and in wider health protection measures to support the Covid response. There will continue to be activity to build on this testing legacy to support wider population health goals.

Conclusion

The changes above are significant, and they are possible thanks to the progress we have made in our ability to protect our population from the most severe harms of COVID 19 through vaccinations and through new treatments. Diagnostics will remain critical – not least as part of our efforts to remain vigilant and be prepared for future pandemic phases. Their purpose is now changing, and we will continue to ensure they play a key role, in our ongoing management of COVID 19; in our wider pandemic preparedness and in our ongoing efforts to improve the health of Scotland's population.

Annex A

Transition Plan Timeline



Step 1 – 17 April
(most asymptomatic testing ends)

Step 2 – 30 April
(symptomatic testing ends)



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W W W . g o v . s c o t

7.2 Healthcare Associated Infection Reporting Template For Assurance

Executive Sponsor: Prof Angela Wallace, HAI Executive Lead

Author: Mr Jonathan Horwood, Area Infection Control Manager

Executive Summary

The Healthcare Associated Infection Reporting Template (HAIRT) is mandatory reporting tool for the Board to have oversight of the HAI targets (*Staph aureus* bacteraemias (SABs), *Clostridioides difficile* infections (CDIs), device associated bacteraemias (DABs), incidents and outbreaks and all HAI other activities across NHS Forth Valley.

Recommendation:

The NHS Board is asked to:

- Note the HAIRT report
- Note the performance in respect of the AOP Standards for SABs, DABs, CDIs & ECBs
- Note the detailed activity in support of the prevention and control of Health Associated Infection

Key Issues to be Considered:

- Total SABs remain within control limits. There was one hospital acquired SAB in February.
- Total DABs remain within control limits. There were two hospital acquired DABs in February.
- Total CDIs remain within normal control limits. There was one hospital acquired CDI in February.
- Total ECBs remain within normal control limits. There was one hospital acquired ECB in February.
- There have been no deaths with MRSA or *C.difficile* recorded on the death certificate.
- There were no surgical site infections in February.
- There were three outbreaks reported in February.

Financial Implications

None

Workforce Implications

None

Risk Assessment

Work is on trajectory to reduce all reducible SABs, DABs, ECBs and CDI infections across NHSFV to meet both national and local standards/expectations.

Relevance to Strategic Priorities

AOP Standards in respect of SABs, ECBs, DABs & CDIs

- *Staph aureus* bacteraemia (SABs)
There were 3 SABs this month. To date, trajectory for achieving the AOP target is being met
- *Clostridioides difficile* infection (CDIs)
There was 1 CDI this month. To date, trajectory for achieving the AOP target is being met.
- *Escherichia coli* bacteraemias (ECBs)
There were 11 ECBs this month. To date, achieving the AOP target is off trajectory and unlikely to be met.
- Device associated bacteraemias (DABs)
There were 7 DABs this month. DABs remain within control limits.

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.

Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity

Consultation Process

Infection Prevention and Control Team

Healthcare Associated Infection Reporting Template (HAIRT)

February 2022

NHS Forth Valley



**Infection Prevention
& Control Team**

HAI Summary

The HAIRT Report is the national mandatory reporting tool and is presented bi-monthly to the NHS Board. This is a requirement by the Scottish Government HAI task Force and informs NHS Forth Valley (NHSFV) of activity and performance against Healthcare Associated Infection Standards and performance measures.

This section of the report focuses on NHSFV Board wide prevention and control activity and actions.

SUMMARY FOR THIS MONTH

- COVID-19 inpatient numbers have remained relatively stable this month. There have been 2 reported outbreaks of Covid this month, CCHC Ward 2 and Ward A32 FVRH.
- There was one reported norovirus outbreak this month in ward B31 FVRH.

Performance at a glance

	No of Cases	Month RAG status	RAG status toward AOP target (based on trajectory to March 2022)		
<i>Staphylococcus aureus</i> bacteraemia (SABs)	3			↔	
<i>Clostridioides difficile</i> infection (CDIs)	1			↓	
<i>Escherichia coli</i> Bacteraemia (ECB)	11			↓	
Device associated bacteraemia (DABs)	7				
Hand Hygiene (SPSP)	98%				
National Cleaning compliance (Board wide)	95%				
National Estates compliance (Board wide)	95%				
Surgical Site Infection Surveillance (SSIS)	0				

Key infection control challenges (relating to performance)

Staph aureus bacteraemia

- There was one hospital acquired SAB this month.
- There were two healthcare acquired SABs this month.
- Total SAB case numbers remained within control limits this month.

Device associated bacteraemia

- There were two hospital acquired DABs this month.
- There were four healthcare acquired DABs this month.
- There was one nursing home acquired DAB this month.
- Total DAB case numbers remained within control limits this month.

E coli bacteraemia

- There was one hospital acquired ECB this month.
- There were 8 healthcare acquired ECBs this month.
- There were two nursing home acquired ECBs this month.
- Total ECBs case remained within control limits this month.

Clostridioides difficile infection

- There was one hospital acquired CDI this month.
- CDI case numbers remain within control limits this month.

Surgical site infection surveillance

- There were no surgical site infections reported this month.

Key HAI related activities

- There were no MRSA or *C. difficile* recorded deaths reported this month.

Glossary of abbreviations

Following feedback from stakeholders below is a list of abbreviations used within this report:

HAI - Healthcare Acquired Infection

SAB – *Staphylococcus aureus* bacteraemia

DAB – Device Associated Bacteraemia

CDI – *Clostridioides* Infection

AOP – Annual Operational Plan

NES – National Education for Scotland

IPCT – Infection Prevention & Control Team

HEI – Healthcare Environment Inspectorate

SSI – Surgical Site Infection

SICPs – Standard Infection Control Precautions

PVC - Peripheral Vascular Catheter

Definitions used for *Staph aureus*, device associated and *E coli* bacteraemias

Definition of a bacteraemia

Bacteraemia is the presence of bacteria in the blood. Blood is normally a sterile environment, so the detection of bacteria in the blood (most commonly accomplished by blood cultures) is always abnormal. It is distinct from sepsis, which is the host response to the bacteria. Bacteria can enter the bloodstream as a severe complication of infection (like pneumonia, meningitis, urinary tract infections etc), during surgery, or due to invasive devices such as PVCs, Hickman lines, urinary catheters etc. Transient bacteraemias can result after dental procedures or even brushing of teeth although this poses little or no threat to the person in normal situations.

Bacteraemia can have several important health consequences. The immune response to the bacteria can cause sepsis and septic shock, which has a high mortality rate. Bacteria can also spread via the blood to other parts of the body (haematogenous spread), causing infections away from the original site of infection, such as endocarditis (infection of the heart valves) or osteomyelitis (infection of the bones). Treatment for bacteraemia is with antibiotics for many weeks in some circumstances, however cases such as *Staph aureus* bacteraemia usually 14 days of antibiotic therapy is required.

Cause definitions for *Staph aureus* and device associated bacteraemia

Hospital acquired

- Hospital acquired is defined when a positive blood culture is taken >48 hours after admission ie the sepsis is not associated with the cause of admission. An example would a patient with sepsis associated from an infected peripheral vascular catheter.

Healthcare acquired

- Healthcare acquired is defined when a positive blood culture is taken <48 hours after admission but has in the last three months had healthcare intervention such as previous hospital admission, attending Clinics, GP, dentist etc. Note this does not necessarily mean that the sepsis is associated with the previous healthcare intervention.

Nursing home acquired

- Nursing home acquired is defined when a positive blood is taken <48 hours after admission and when symptoms associated with sepsis developed at the nursing home

HAI Surveillance

NHS FV has systems in place to monitor key targets and areas for delivery. Our surveillance and HAI systems and ways of working allow early detection and indication of areas of concern or deteriorating performance. The Infection Prevention & Control Team undertakes over 180 formal ward audits per month in addition to regular weekly ward visits by the Infection Control Nurse; infection investigation is also a significant function within the team as part of our AOP target reporting. This activity provides robust intelligence of how infection prevention is maintained across all areas in Forth Valley and is reported on a monthly basis to all appropriate stakeholders.

Staph aureus bacteraemias (SABs)

All blood cultures that grow bacteria are reported nationally and it was found that *Staph aureus* became the most common bacteria isolated from blood culture. As *Staph aureus* is an organism that is found commonly on skin it was assumed (nationally) the bacteraemias occurred via a device such as a peripheral vascular catheter (PVC) and as such a national reduction strategy was initiated and became part of the then HEAT targets in 2006. The target was a national reduction rather than a board specific reduction, however the latest target set for 2019-2022 are board specific, based on our current infection rates.

NHS Forth Valley's approach to SAB prevention and reduction

All *Staph aureus* bacteraemia are monitored and reported by the IPCT. Investigations to the cause of infection consist of examining the patients notes, microbiology, biochemistry and haematology reports to identify potential causes of the infection; from this, in most cases, a provisional cause is identified, however this is discussed further with the clinical team responsible for the management of the patient to assist further with the investigation. Any issues identified during the investigations, such as incomplete bundle completion etc is highlighted at this time and where appropriate an IR1 is reported. Once a conclusion has been agreed, the investigations are presented to the Infection Control Doctor/Microbiologist for approval. The investigation is concluded with the IPCT reporting their findings to the clinical team and management.

This data is entered into the IPCT database collated, analysed and reported on a monthly basis. The analysis of the data enables the IPCT to identify trends in particular sources of infections, such as Hickman line infections etc and identifying areas requiring further support. The data also influences the direction of the HAI annual workplan.

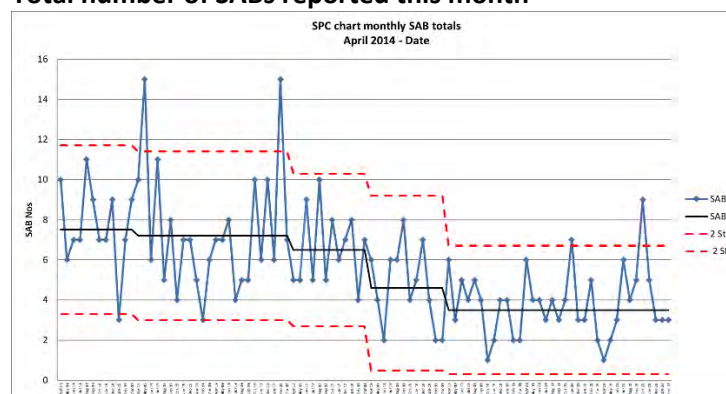
February 2022

Monthly Total	3
Hospital	1
Healthcare	2
Nursing Home	0

RAG Status - Green denotes monthly case numbers are less than the mean monthly SAB totals. Amber denotes when monthly case numbers are above the mean monthly SAB totals but less than two standard deviations from the mean. Red denotes monthly case numbers are above two standard deviations from the monthly mean.

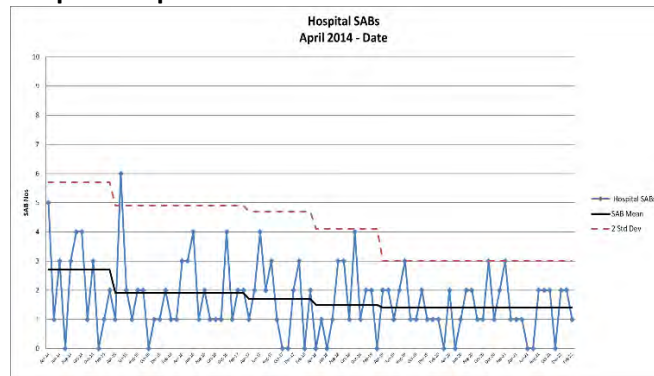
Staph aureus bacteraemia total - April 21 to date – 44

Total number of SABs reported this month



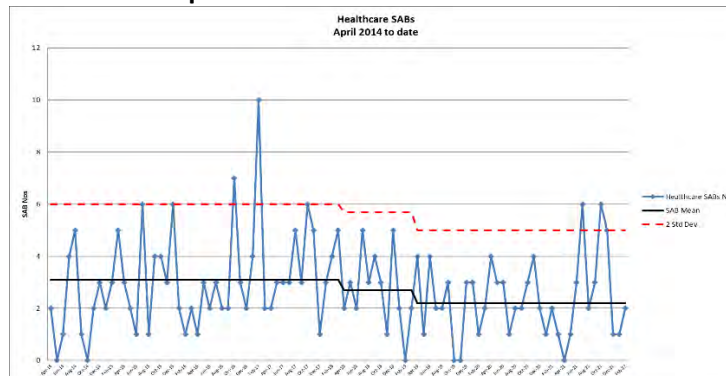
Comments: Case numbers remain within control limits this month. No concerns to raise.

Hospital Acquired SABs



Comments: Case numbers remain within control limits this month. No concerns to raise.

Healthcare Acquired SABs



Comments: Case numbers remain within control limits this month. No concerns to raise.

Breakdown

Source	Case Numbers
Healthcare	
Permacath	2
Hospital	
PVC	1
No attributed ward	
Grand Total	3

There were 424 blood cultures taken this month, of those there were in total 3 blood cultures that grew *Staph aureus*. This accounts for 0.6% of all blood cultures taken this month. There was one hospital acquired SABs this month, this accounts for 0.2% of all blood cultures.

There was one hospital SAB reported this month.

- PVC: Infection developed following patient tampering with insertion site.

Directorate reports and graphs can be accessed using the following link:

<https://staffnet.fv.scot.nhs.uk/infection-control/monthly-ward-reports/>

Device Associated Bacteraemias (DABs)

In addition to the nationally set targets, infections from an invasive device caused by *Staph aureus* would be investigated fully and reported, any other organism causing the same infection was not mandated to report nationally or to be investigated. As a result of this, in 2014, the IPCT started reporting all bacteraemias attributed to an invasive device regardless of the bacterium causing the infection. Due to the importance and significance of this surveillance, it is now part of our local AOP.

NHS Forth Valley's approach to DAB prevention and reduction

Continual monitoring and analysis of local surveillance data enables the IPCT and managers to identify and work towards ways to reduce infections associated with devices. All DABs are reviewed and investigated fully and highlighted to the patients' clinicians, nursing staff and management. Where appropriate an IR1 is generated to enable infections that require learning is shared and discussed at local clinical governance meetings.

In addition, on a weekly basis the IPCT assess bundle compliance of three invasive devices (PVCs, urinary catheters, CVCs etc) as part of their ward visit programme and this is reported in the monthly Directorate Reports.

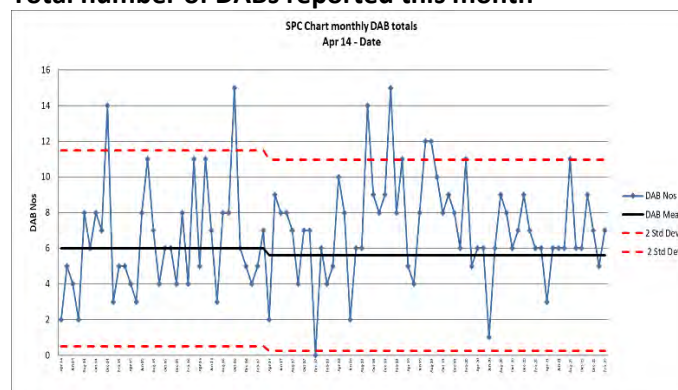
February 2022

Monthly Total	7
Hospital	2
Healthcare	4
Nursing Home	1

RAG Status - Green denotes monthly case numbers are less than the mean monthly CDI totals. Amber denotes when monthly case numbers are above the monthly mean but less than two standard deviations from the monthly mean. Red denotes monthly case numbers are above two standard deviations from the monthly mean.

Device associated bacteraemia total – April 21 to date -
72

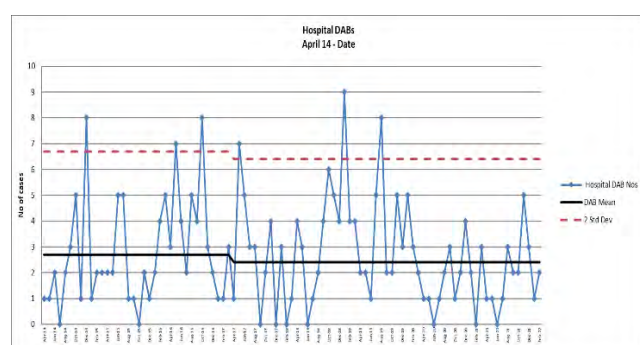
Total number of DABs reported this month



Comments:

Case numbers remain within control limits, no concerns to raise.

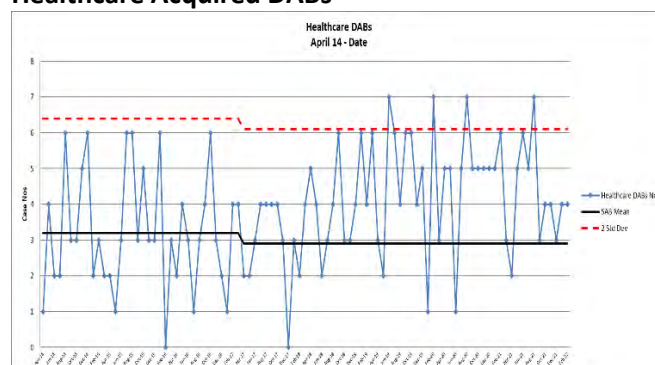
Hospital Acquired DABs



Comments:

Case numbers remain within control limits, no concerns to raise.

Healthcare Acquired DABs



Comments:

Case numbers remain within control limits, no concerns to raise.

Breakdown

Source	No. of infections
Healthcare	4
Urinary Catheter long term	2
Permacath	2
Hospital	2
PVC	1
No attributed ward	
PICC line	1
B32	
Nursing home	1
Stent	1
Grand Total	7

There were 484 blood cultures taken this month, of those there were in total 7 blood cultures that were associated with devices. This accounts for 1.4% of all blood cultures taken this month. There were two hospital acquired DABs this month, this accounts for 0.4% of all blood cultures taken this month.

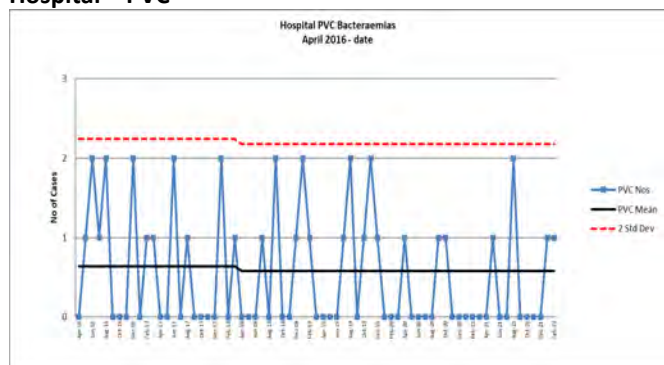
Hospital DABs

- PVC - Infection developed following patient tampering with insertion site.
- PICC line attributed to ward B32 – Documentation incomplete.

Directorate reports and graphs can be accessed using the following link:

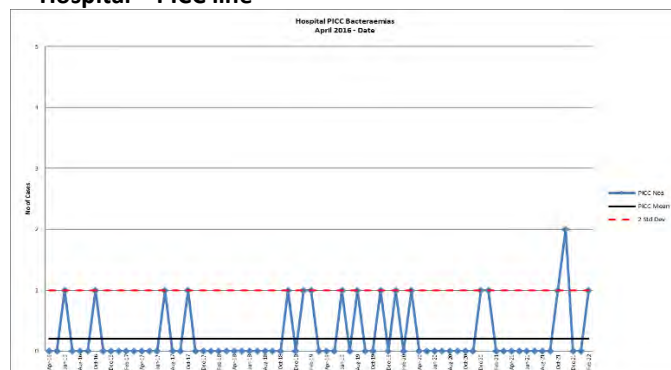
<https://staffnet.fv.scot.nhs.uk/infection-control/monthly-ward-reports/>

Hospital – PVC



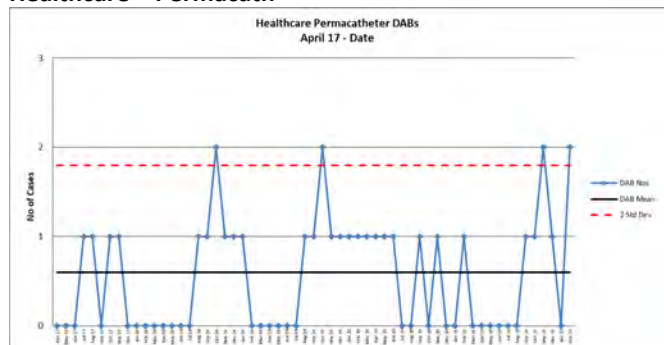
Comments: case numbers remain within control limits, no concerns to raise.

Hospital – PICC line



Comments: case numbers remain within control limits, no concerns to raise.

Healthcare – Permacath



Comments: Case numbers exceeded control limits this month. Investigations identified both patients did not wear any dressings over the permacatheter which led to infection.

Escherichia coli Bacteraemia (ECB)

NHS Forth Valley's approach to ECB prevention and reduction

E coli is one of the most predominant organism of the gut flora and for the last several years the incidence of Ecoli isolated from blood cultures ie causing sepsis, has increase so much that it is the most frequently isolated organism in the UK. As a result of this, the HAI Policy Unit has now included E coli as part of the AOP targets. The most common cause of E coli bacteraemia (ECB) is from complications arising from urinary tract infections (UTIs), hepato-biliary infections (gall bladder infections) and urinary catheters infections.

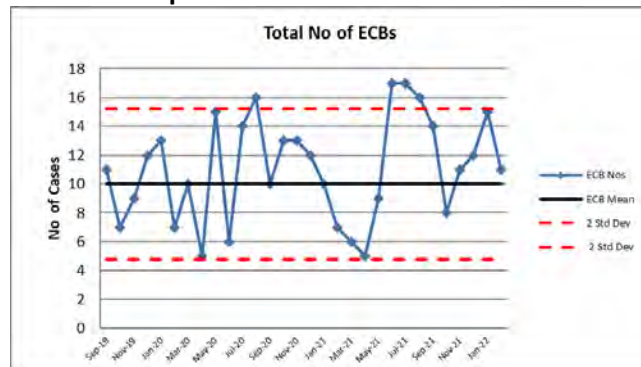
In NHS FV, device associated bacteraemias (DABs) surveillance has been ongoing since 2014 and have seen a reduction in urinary catheter bacteraemias over the years including Ecoli associated infections and will hope to continue to reduce so to achieve our target for 2022.

February 2022

Monthly Total	11
Hospital	1
Healthcare	8
Nursing Home	2

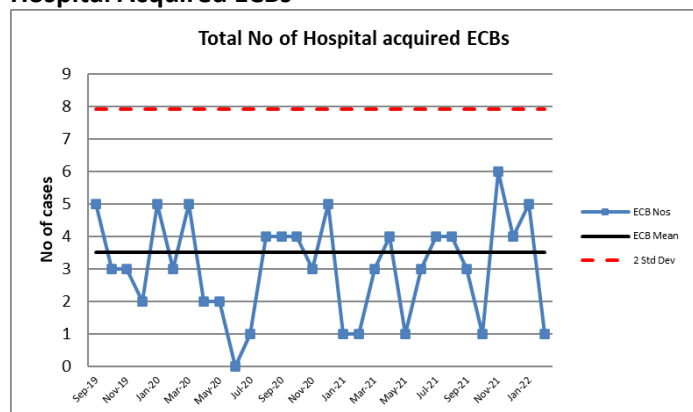
E coli bacteraemia infection total – April 21 to date - 136

Total ECBs reported this month



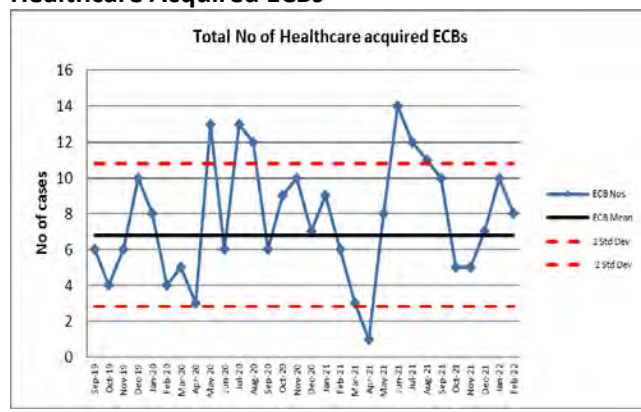
Comments: case numbers remain within control limits, no concerns to raise.

Hospital Acquired ECBs



Comments: case numbers remain within control limits, no concerns to raise.

Healthcare Acquired ECBs



Comments: case numbers remain within control limits, no concerns to raise.

Breakdown

Source	No. of infections
Healthcare	8
Urinary Catheter long term	2
UTI	1
Post procedural	1
Biliary tract	1
Pyelonephritis	3
Hospital	1
Post procedural	1
No attributed ward	
Nursing home	2
Biliary tract	1
Stent	1
Grand Total	11

There were 484 blood cultures taken this month, of those there were in total 11 blood cultures that grew *E. coli*. This accounts for 2.3% of all blood cultures taken this month. Hospital ECBs accounted for 0.2% of all blood cultures taken.

Hospital ECBs

- Post procedural - Infection developed following surgery.

Directorate reports and graphs can be accessed using the following link:

<https://staffnet.fv.scot.nhs.uk/infection-control/monthly-ward-reports/>

Clostridioides difficile infection (CDIs)

Following the Vale of Leven outbreak in 2007 where 131 patients were infected with *C. difficile* resulting in 34 deaths, it became mandatory for all health boards to monitor, investigate and report all infections associated with *C. difficile*. NHSFV has met its targets over the years and has maintained a low rate of infection. Similar to the SAB target, the new target set for 2019-2022 is based on Forth Valley's rate rather than an overall national rate.

C. difficile can be part of the normal gut flora and can occur when patients receive broad spectrum antibiotics which eliminate other gut flora allowing *C. difficile* to proliferate and cause infection. This is the predominant source of infection in Forth Valley. *C. difficile* in the environment can form resilient spores which enable the organism to survive in the environment for many months and poor environmental cleaning or poor hand hygiene can lead to the organism transferring to other patients leading to infection (as what happened in the Vale of Leven hospital). Another route of infection is when patient receive treatment to regulate stomach acid which affects the overall pH of the gut allowing the organism to proliferate and cause infection.

Cause definitions for *Clostridioides difficile* infections

Hospital acquired

- Hospital acquired is defined when symptoms develop and confirmed by the laboratory >48 hours after admission which were not associated with the initial cause of admission.

Healthcare acquired

- Healthcare acquired is defined as having symptoms that develop and confirmed by the laboratory prior to or within 48 hours of admission and has in the last three months had healthcare interventions such as previous hospital admission, attending Clinics, GP, dentist etc

Nursing home acquired

- Nursing home acquired is defined as having symptoms that develop and confirmed by the laboratory that developed at the nursing home prior to admission

NHS Forth Valley's approach to CDI prevention and reduction

Similar to our SABs and DABs investigation, patient history is gathered including any antibiotics prescribed over the last few months. Discussion with the clinical teams and microbiologists assist in the determination and conclusion of the significance of the organism, as sometimes the organism isolated can be an incidental finding and not the cause of infection. Data is shared with the antimicrobial pharmacist and cases are discussed at the Antimicrobial Management Group to identify inappropriate antimicrobial prescribing.

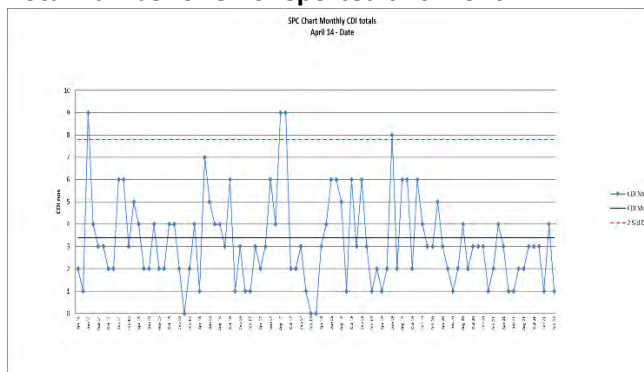
February 2022

Monthly Total	1
Hospital	1
Healthcare	0
Nursing Home	0

RAG Status - Green denotes monthly case numbers are less than the mean monthly CDI totals. Amber denotes when monthly case numbers are above the monthly mean but less than two standard deviations from the monthly mean. Red denotes monthly case numbers are above two standard deviations from the monthly mean.

Clostridioides difficile infection total – April 21 to date – 24

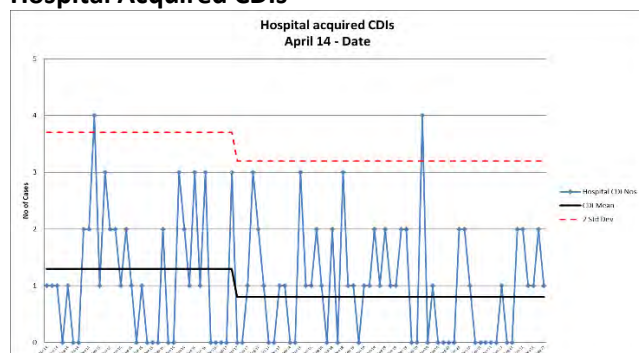
Total number of CDIs reported this month



Comments:

Case numbers remain within control limits, no concerns to raise.

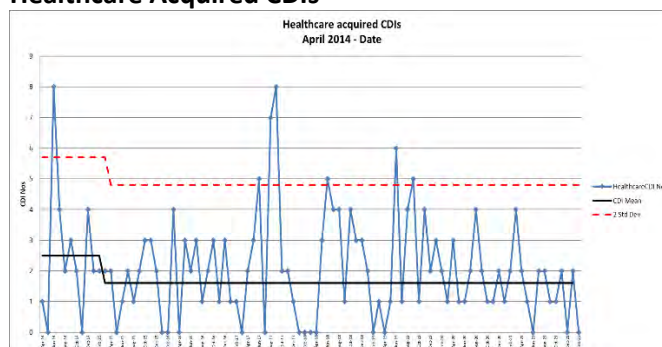
Hospital Acquired CDIs



Comments:

Case numbers remain within control limits, no concerns to raise.

Healthcare Acquired CDIs



Comments:

Case numbers remain within control limits, no concerns to raise.

Breakdown

Source	No. of infections
Hospital	1
No attributed ward	1
Grand Total	1

Hospital CDIs:

- No ward attributed. Patient admitted with urosepsis. Treated with appropriately with antibiotics prior to developing infection.

Directorate reports and graphs can be accessed using the following link:

<https://staffnet.fv.scot.nhs.uk/infection-control/monthly-ward-reports/>

AOP TARGETS

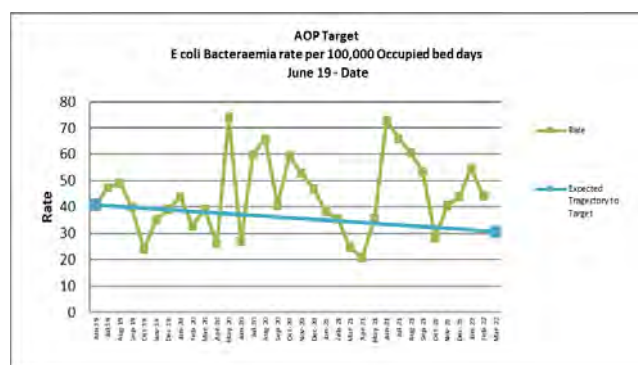
New HAI AOP targets for 2019-2022

On the 10th October 2019, a letter was sent to all Health Board Chief Executives highlighting our new HAI targets. These targets are based on our (Forth Valley) current rates of infection and a percentage reduction has been set to be achieved by March 2022. This target is different from our previous targets and includes the reduction in hospital and healthcare acquired infections and does not include community acquired. (*note, community acquired infections are included in this report. The data will be adjusted in next and subsequent reports*). Hospital and healthcare acquired infections are now classified as healthcare infections as it is perceived nationally that all hospital and healthcare infections are all reducible. For continuity, we will continue to report separately hospital and healthcare infections to maintain our quality and transparency in our data, however, the total number of infections will reflect on what we are reported nationally and in line with our set targets. In addition to SABs and CDIs targets, *Escherichia coli* bacteraemia (ECB) is now included in our targets.

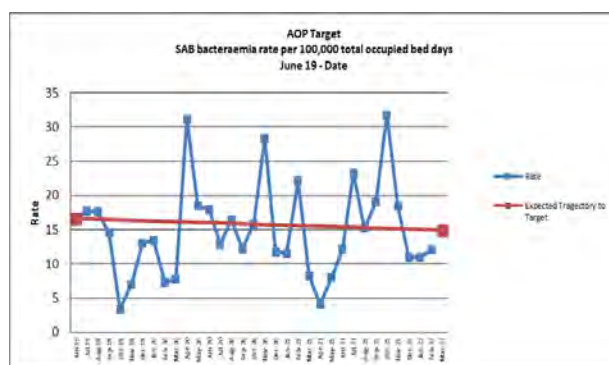
The data is currently being reformatted to address these targets and will be included in future reports. Please see table below for our new targets:

	2018/19 Rate (base line) per 100,000 total bed days	No of cases (per annum)	Reduction %	Date for reduction	Target rate per 100,000 total bed days	Target cases per annum
ECB	40.8	135	25	2022	30.6	101
SAB	16.6	55	10	2022	14.9	50
CDI	11.4	38	10	2022	10.3	34

AOP target progress to date



Comments: Infection rate has decreased this month. It is anticipated that FV will not achieve the target rate by March 2022.



Comments: Infection rate has increased this month and remains on target.



Comments: Infection rate have decreased this month and remains on target

Target Organism	Target Rate (per 100,000 total bed days)	Current Rate April 21 - date (per 100,000 total bed days)	Status
ECB	30.6	47.4	Unlikely to achieve target
SAB	14.9	15.08	Likely to achieve target
CDI	10.3	8.3	Likely to achieve target

Surgical Site Infection Surveillance (SSIS)

Surgical site infection surveillance is the monitoring and detection of infections associated with a surgical procedure. In Forth Valley, the procedures include, hip arthroplasty, Caesarean section, abdominal hysterectomy, major vascular surgery, large bowel, knee arthroplasty and breast surgeries. We monitor patients for 30 days post surgery including any microbiological investigations from the ward/GP for potential infections and also hospital readmissions relating to their surgery. Any infection associated with a surgical procedure is reported nationally to enable board to board comparison. NHS Forth Valley infection rates are comparable to national infection rates.

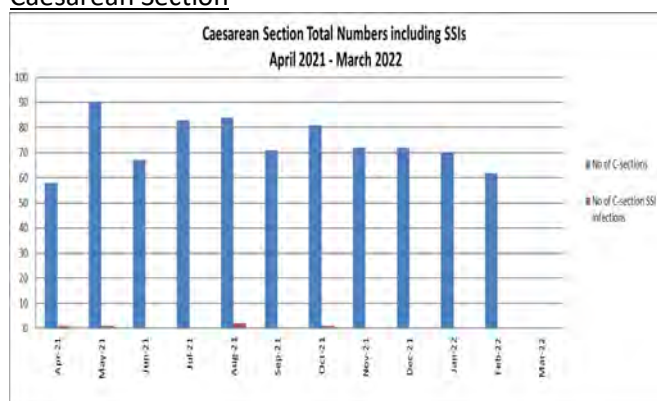
NHS Forth Valley's approach to SSI prevention and reduction

Surgical site infection criteria is determined using the European Centre for Disease Control (ECDC) definitions. Any infection identified is investigated fully and information gathered including the patients weight, duration of surgery, grade of surgeon, antibiotics given, theatre room, elective or emergency etc can provide additional intelligence in reduction strategies. The IPCT monitor closely infection rates and any increases of SSIs are reported to management and clinical teams to enable collaborative working to reduce infection rates.

Breakdown

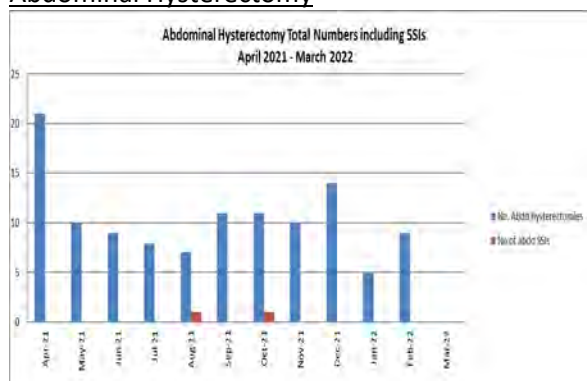
Procedure	Confirmed SSI
Abdominal Hysterectomy (v)	0
Breast Surgery (v)	0
Caesarean Section (m)	0
Knee Arthroplasty (v)	0
Hip Arthroplasty (m)	0
Major Vascular Surgery (m)	0
Large Bowel Surgery (m)	0

Caesarean Section



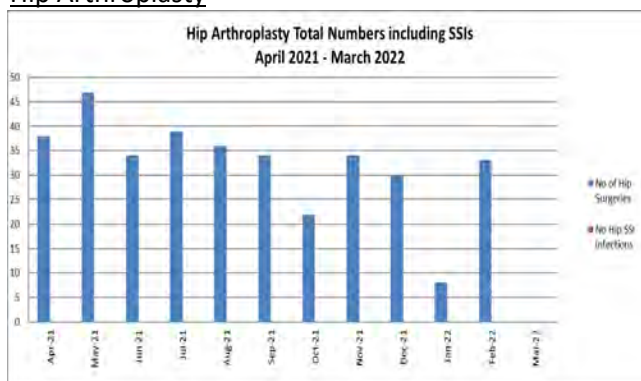
Comments: case numbers remain within control limits, no concerns to raise.

Abdominal Hysterectomy



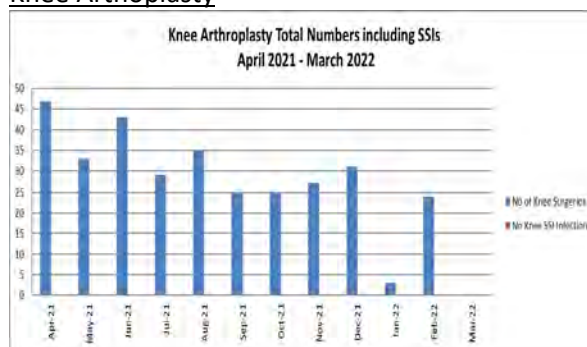
Comments: case numbers remain within control limits, no concerns to raise.

Hip Arthroplasty



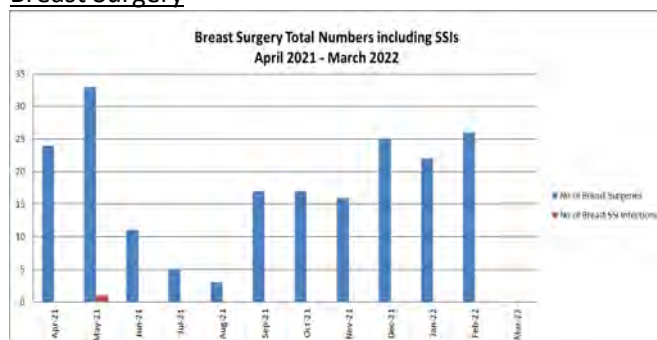
Comments: case numbers remain within control limits, no concerns to raise.

Knee Arthroplasty



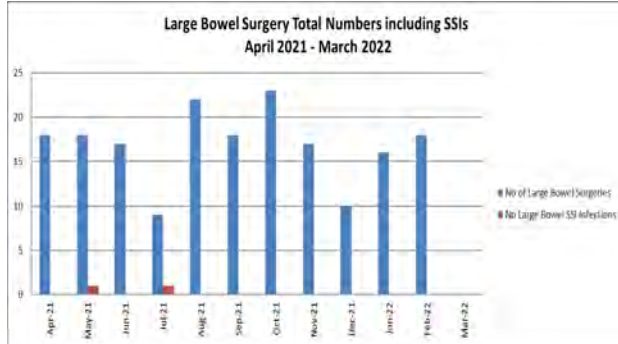
Comments: case numbers remain within control limits, no concerns to raise.

Breast Surgery



Comments: case numbers remain within control limits, no concerns to raise.

Large Bowel Surgery



Comments: case numbers remain within control limits, no concerns to raise.

National surveillance reporting has been suspended due to COVID-19.

Meticillin resistant *Staphylococcus aureus* (MRSA) & *Clostridioides difficile* recorded deaths

The National Records of Scotland monitor and report on a variety of deaths recorded on the death certificate. Two organisms are monitored and reported, MRSA and *C. difficile*. Please click on the link below for further information:

<https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths>

This month, there were no *C. difficile* or MRSA recorded deaths reported this month.

SPSP Hand Hygiene Monitoring Compliance (%) Board wide

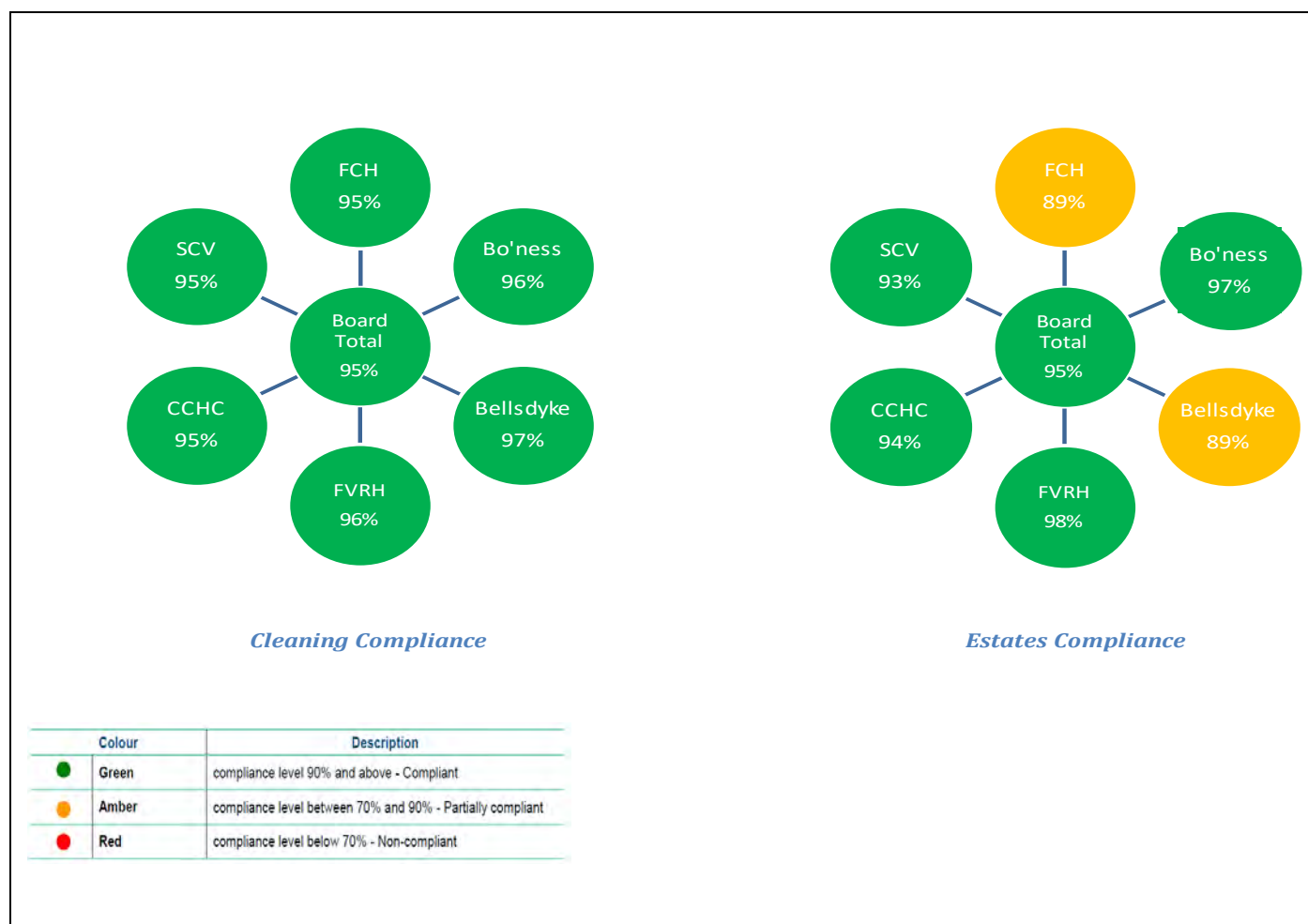
Data taken from TCAB (self reported by ward staff)

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022
Board Total	99	99	99	99	98	99	98	98	98	98	99	98

Estate and Cleaning Compliance (per hospital)

The data is collected through audit by the Domestic Services team using the Domestic Monitoring National Tool and areas chosen within each hospital is randomly selected by the audit tool. Any issues such as inadequate cleaning is scored appropriately and if the score is less than 80% then a re-audit is scheduled. Estates compliance is assessed whether the environment can be effectively cleaned; this can be a combination of minor non-compliances such as missing screwcaps, damaged sanitary sealant, scratches to woodwork etc. The results of these findings are shared with Serco/Estates for repair. Similar to the cleaning audit, scores below 80% triggers a re-audit.

Estates & Cleaning Scores October – December 2021 (Quarter 4)



Bellsdyke Hospital & Falkirk Community Hospital Estate Scores

This quarter, the estate score from Bellsdyke Hospital and Falkirk Community Hospitals have remained relatively stable this quarter compared to the previous quarter (Bellsdyke 88%, Falkirk Community Hospital 89%).

Ward Visit Programme

Below are table and graphs detailing the non-compliances identified during the ward visits.

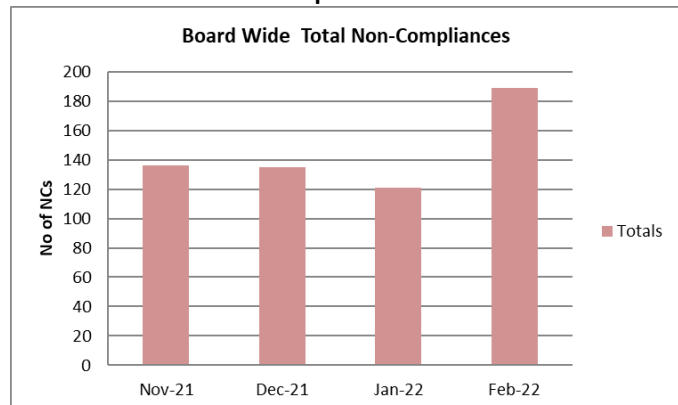
	Patient Placement	Hand Hygiene	PPE	Managing Patient Care Equipment	Control of the Environment	Safe Management of Linen	Safe Disposal of Waste	Totals
Acute Services	11	5	16	70	40	19	22	183
Primary Care & Mental Health Services	0	0	1	1	1	0	1	4
WC&SH Directorate	0	0	0	1	0	1	0	2
Totals	11	5	17	71	41	19	23	189

All non-compliances are fed back to the nurse in charge immediately following the ward visit. A follow-up email is also sent to the ward and service manager. Details of each non-compliance are reported in the monthly HAI Service Reports.

The purpose of these audits is to assess compliance to standard infection control precautions (SICPs); each aspect or SICP can be contributory factors to infection.

The predominant non-compliance reported this month was Control of the Environment category; non-compliances included area not free from clutter, area not well maintained and in good state of repair, inappropriate items in clinical area (i.e. staff belongings / coffee cups) and all stores are not above floor level. All non-compliances were highlighted to the nurse in charge at the time of audit and any equipment with cleanliness issues was rectified immediately. Other non-compliances such as Managing Patient Care Equipment, non compliances included indicator tape /label missing, equipment visibly dirty, items stored inappropriately.

Board Wide Total Non-Compliances



Comments: Non-compliances have increased this month.

Acute Services Total Non-Compliances



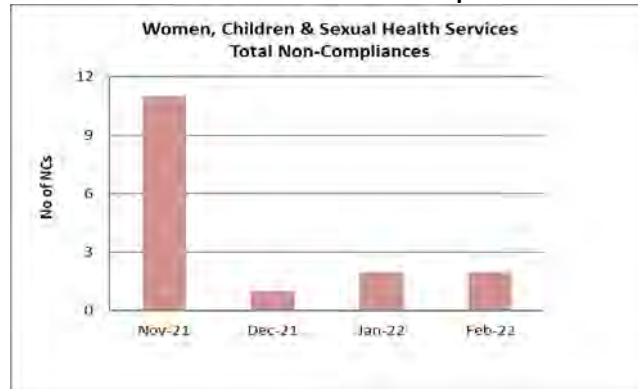
Comments: Non-compliances have increased this month.

Primary Care & MH Services Total Non-Compliances



Comments: Non-compliances have decreased this month.

Women & Children & SH Total Non-Compliances



Comments: Non-compliances have remained the same this month.

Incidence / Outbreaks

All outbreaks are notified to Health Protection Scotland and Scottish Government (see below for further details).

Healthcare Acquired Infection Incident Template (HAIT)

The HAIT is a tool used by boards to assess the impact of an incident or outbreak. The tool is a risk assessment and allows boards to rate the incident/outbreak as a red, amber, or green. The tool also directs boards whether to inform ARHAI Scotland/SG of the incident (if amber or red), release a media statement etc.

There was one outbreak of norovirus reported this month:

Ward	No of patients affected
Ward B31 FVRH	5

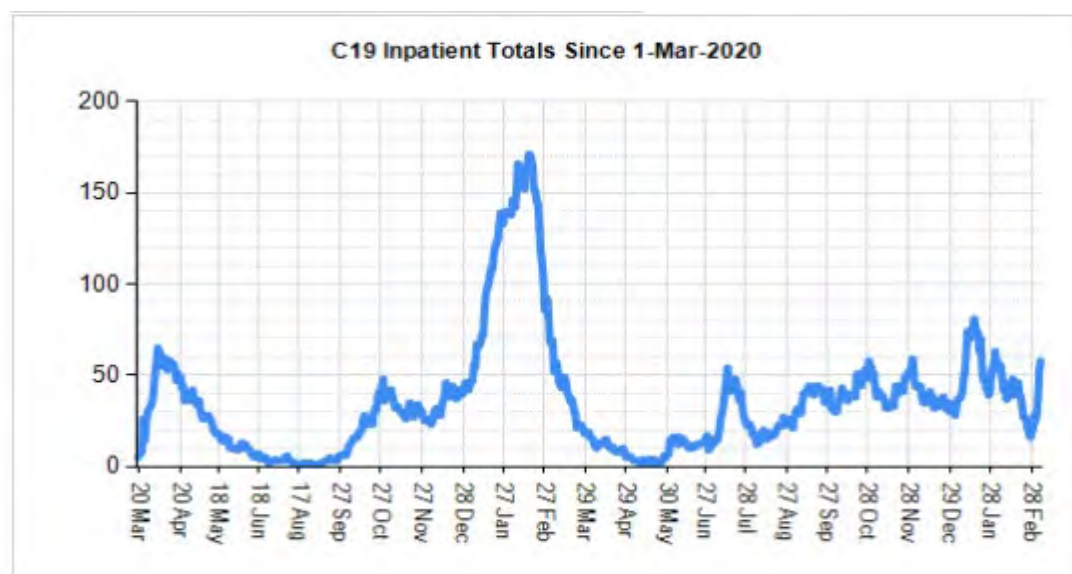
There were two COVID-19 outbreaks reported this month:

Ward	No of patients affected
Ward A32 FVRH	6
CCHC Ward 2	7

Note: symptoms of patients affected during the outbreaks were generally very mild or had no symptoms at all

COVID-19

Covid-19 admissions and overall inpatient numbers in February have remained relatively stable throughout the month. See graph below of the inpatient case numbers.



On a weekly basis Health Protection Scotland publish infection figures based on electronic data submitted to them on the rate of COVID-19 infection that has been acquired during the patients hospital stay. This is calculated solely based on the time the patient was admitted to the hospital and the incubation period of COVID-19 (14 days). For example, if a patient stay has exceeded 14 days and became COVID-19 positive after day 14 then it is determined to be hospital acquired. Based on purely on admission times does not necessarily mean hospital acquired, however, these are the limitations of the data and the report. NHS Forth Valley's rate for hospital onset COVID is currently 0.4% compared to the national rate of 0.4%.

The table below shows the latest report and Forth Valley's position nationally up to 13th February 2022.

Table 1: Number of COVID-19 cases, by onset status and NHS board: specimen dates up to 13 February 2022.^{1,2,3}

NHS-board ^a	Total COVID-19 cases ^b ↑ (n) ^a	Non-hospital-onset ^c ↑ (n) ^a	Indeterminate-hospital-onset-cases ^d ↑ (n) ^a	Probable-hospital-onset-cases ^e ↑ (n) ^a	Definite-hospital-onset-cases ^f ↑ (n) ^a	Non-hospital-onset ^g ↑ (%) ^a	Indeterminate-hospital-onset-cases ^h ↑ (%) ^a	Probable-hospital-onset-cases ⁱ ↑ (%) ^a	Definite-hospital-onset-cases ^j ↑ (%) ^a
Ayrshire & Arran ^a	90,488 ^a	1,422 ^a	191 ^a	333 ^a	665 ^a	1.6% ^a	0.2% ^a	0.4% ^a	0.7% ^a
Borders ^a	20,667 ^a	191 ^a	35 ^a	51 ^a	117 ^a	0.9% ^a	0.2% ^a	0.2% ^a	0.6% ^a
Dumfries & Galloway ^a	29,909 ^a	437 ^a	40 ^a	17 ^a	57 ^a	1.5% ^a	0.1% ^a	0.1% ^a	0.2% ^a
Fife ^a	88,017 ^a	972 ^a	81 ^a	67 ^a	378 ^a	1.1% ^a	0.1% ^a	0.1% ^a	0.4% ^a
Forth Valley ^a	76,445 ^a	1,077 ^a	118 ^a	107 ^a	281 ^a	1.4% ^a	0.2% ^a	0.1% ^a	0.4% ^a
Golden Jubilee ^a	44 ^a	28 ^a	8 ^a	3 ^a	5 ^a	- ^a	- ^a	- ^a	- ^a
Grampian ^a	116,895 ^a	908 ^a	106 ^a	108 ^a	306 ^a	0.8% ^a	0.1% ^a	0.1% ^a	0.3% ^a
Greater Glasgow & Clyde ^a	323,303 ^a	4,121 ^a	728 ^a	795 ^a	1,920 ^a	1.3% ^a	0.2% ^a	0.2% ^a	0.6% ^a
Highland ^a	53,624 ^a	370 ^a	24 ^a	12 ^a	65 ^a	0.7% ^a	0.0% ^a	0.0% ^a	0.1% ^a
Lanarkshire ^a	190,230 ^a	1,534 ^a	319 ^a	355 ^a	699 ^a	0.8% ^a	0.2% ^a	0.2% ^a	0.4% ^a
Lothian ^a	221,001 ^a	2,289 ^a	299 ^a	396 ^a	882 ^a	1.0% ^a	0.1% ^a	0.2% ^a	0.4% ^a
Orkney ^a	2,545 ^a	15 ^a	1 ^a	1 ^a	5 ^a	0.6% ^a	0.0% ^a	0.0% ^a	0.2% ^a
Shetland ^a	3,009 ^a	20 ^a	1 ^a	0 ^a	0 ^a	0.7% ^a	0.0% ^a	0.0% ^a	0.0% ^a
Tayside ^a	93,868 ^a	1,404 ^a	166 ^a	193 ^a	439 ^a	1.5% ^a	0.2% ^a	0.2% ^a	0.5% ^a
Western Isles ^a	2,862 ^a	23 ^a	1 ^a	3 ^a	8 ^a	0.8% ^a	0.0% ^a	0.1% ^a	0.3% ^a
Scotland^a	1,312,907^a	14,811^a	2,118^a	2,441^a	5,827^a	1.1%^a	0.2%^a	0.2%^a	0.4%^a

Care Homes

Care home across Forth Valley continue to be challenged due to the sustained rate of covid-19 infection in the community. On a daily basis, collaborative decision making, reporting and escalating at a local HSCP level with input from Public Health, Infection Control and Nursing Assurance/Outreach teams support care home providers in maintaining the safety and wellbeing of residents and staff.

Risk assessment

There are a number of homes that have Covid-19 positive staff but following risk assessment and enhanced procedures in place, they remain open to admissions and visiting and are listed further below. It should also be noted that admissions during an outbreak may still be possible on occasion when a resident is positive depending on the assessment around that situation and the agreed criteria protocol is followed.

Care home situation as at 7th March 2022

Description	Total	Trend
Number of FV homes currently in formal Covid-19 Outbreak (see detail below)	9	↔
Number of Care Homes with Positive residents	13	↑
Number of Care Homes experiencing Covid	29	↓
Homes in Outbreak with positive staff	8	↓
Number of Care Homes with positive staff	27	↓

Care homes in formal Covid-19 outbreak

Care Home	Residents	Staff	Care Home	Residents	Staff
Falkirk Homes			Clacks & Stirling Homes		
Barleystone	21	11	Deanston House	2	3
Carrondale	0	4	Fairview	8	1
Glenbervie	3	2	Marchglen	3	4
Summerford	5	6	Roselea Court	3	1
The Haining	1	0			

All care homes with positive staff implement their own contingency plans for safe staffing in first instance and can also be provided by agency and bank staff. In the event of increased staffing issues due to outbreaks etc, additional support can be mobilised from HSCPs and also from the Clinical Outreach team.

FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

7.3 Recovery & Performance Scorecard For Assurance

Executive Sponsor: Mrs Cathie Cowan, Chief Executive

Author: Ms Kerry Mackenzie, Head of Policy & Performance

Executive Summary

The overall approach to performance within NHS Forth Valley underlines the principle that performance management is integral to the delivery of quality improvement and core to sound management, governance, and accountability. The Recovery & Performance Scorecard is presented to enable the NHS Board and the Performance & Resources Committee to fulfil their responsibility in respect of effective monitoring of system-wide performance.

Recommendation

The Forth Valley NHS Board is asked to:

- **note** the current key performance issues
- **note** the detail within the Recovery & Performance Scorecard

Key Issues to be Considered

The Recovery & Performance Scorecard considers our System-Wide Remobilisation Plan which sets out how we safely continue the resumption of services whilst taking account of the different ways in which we have been working during the pandemic and considers the ongoing impact as we move forward. Additionally, there is a focus on establishing more of a 'norm' going forward with the inclusion of monthly key performance measures.

The scorecard format has been developed to provides a comprehensive 'at a glance' view of measures. Work is on-going to ensure accuracy of data, that all the definitions and reporting periods remain appropriate and meaningful, and that suggested additions are included where possible. A further review will be scheduled in the new year.

The scorecard is circulated to the System Leadership Team (SLT) and the Non-Executive Directors of the Board on a weekly basis with a full monthly update presented to the NHS Board and Performance & Resources Committee.

Scorecard format

- Notes have been included describing the scorecard headings and providing definitions and detail in relation to the indicators and targets
- The scorecard is split by Recovery Measures, Key Performance Measures, and Response Measures with associated graphs/run charts where relevant
- The majority of Recovery and Response measures are reported on a weekly basis
- Key Performance Measures, which include the eight key standards that are most important to patients, are designed to support the overall recovery position and provide a month on month progress overview

- The eight key standards are: 12 week outpatient target, Diagnostics, 12 week treatment time guarantee, cancer targets, access to Psychological Therapies, access to Child & Adolescent Mental Health Services and Accident & Emergency 4-hour wait
- Where a Forth Valley wide measure is reported any areas of challenging performance within a specialty will be highlighted in the narrative
- Measures, Graphs and Key Performance Issues narrative are linked and should be viewed collectively
- Work is still being undertaken to establish detailed data in respect of one new measure i.e., clinic utilisation.

Key Performance Issues

• *Unscheduled Care*

Overall compliance with the 4 hour target in February 2022 was 76.1%; Minor Injuries Unit 99.9%, Emergency Department 67.1%. A total of 1458 patients waited longer than the 4 hour target across both the ED and Minor Injuries Unit (MIU); with 133 waits longer than eight hours and 15 waits longer than 12 hours. The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 990 patients, an increase from 719 in January. The wait for first assessment is as a result of issues in relation to flow through the system and system-wide pressures.

• *Scheduled Care*

At the end of February 2022, 53.1% of patients were waiting less than 12 weeks for a first appointment; this is slightly better than the previous month. Activity against the agreed Remobilisation Plan trajectory highlights the cumulative position from April 2021 to February 2022 as 96% compliance.

In February 2022, the number of inpatients/daycases waiting increased from 3,648 to 3,921 with an increase in those waiting beyond 12 weeks to 1,785. Activity against the agreed Remobilisation Plan trajectory highlights the cumulative position from April 2021 to February 2022 as 82% compliance.

At the end of February 2022: 2063 patients were waiting beyond 6 weeks for imaging with 65.1% compliance; 270 patients were waiting beyond 6 weeks for endoscopy with 55.0% compliance.

Cancer target compliance in January 2022:

- 62-day target – 76.4% which is a drop in performance from the December position of 80.5%.
- 31-day target – 94.1%. This is the first time compliance has dropped below 95% since January 2019.

• *Psychological Therapies*

In February 2022, 60.0% of patients started treatment within 18 weeks of referral. This is a reduction from the previous month however better than the performance in February 2021 of 53.8%. The Remobilisation Plan trajectory of 60% was exceeded in December with current performance equal to the plan. A robust programme of work is in place to support improvements including engagement with the Scottish Government's Enhanced Support Programme.

• *Child & Adolescent Mental Health Services*

In February 2022, 71.4% of patients started treatment within 18 weeks of referral. This is an improvement from 58.3% in January 2022 and from 38.2% in February 2021. The remobilisation plan trajectory of 45% was exceeded in December 2021 with current performance better than the plan. A multi-level improvement plan is in place with NHS Forth Valley receiving a tailored programme of enhanced improvement support from the Scottish Government.

• *Workforce*

The sickness absence target is 4.0% with NHS Forth Valley working towards a local milestone target of 4.5% agreed at the Staff Governance Committee. Absence remains above the target at 5.63% in January 2022 however is an improvement from the previous month and from 5.76% in January 2021.

The absence for Coronavirus reasons is noted as 4.15% in January 2022; an increase from 3.32% in December 2021. The total absence in January 2022 was 9.78%.

- ***Delayed Discharges***

The February 2022 census position in relation to standard delays (excluding Code 9 and guardianship) is 60 delays; an increase from 57 in January. There was a total of 31 code 9 and guardianships with 2 infection codes noted. In addition, there were 8 code 100 patients (These patients are undergoing a change in care setting and should not be classified as delayed discharges however are monitored).

The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the February 2022 census was 1622, this is a decrease from 1936 in January.

- ***Test & Protect***

The Test and Protect Service continues to work well linking with health protection who manage the more complex cases. We continue to ensure that the prerequisite number of staff is available daily working to support timely contact with the use of a shorter script for Contact Tracers to work through and Text Messaging to inform contacts. The service continues to be busy with the number of cases in excess of 5,000 per week. Routine contact tracing will end on 30 April 2022.

- ***Covid-19 Vaccination***

The Covid-19 vaccination programme continues in line with Scottish Government guidance and Joint Committee on Vaccination and Immunisation (JCVI) recommendations. The programme continues to be delivered along with the Covid-19 booster programme taking account of guidance received. The JCVI advise a spring dose of the coronavirus (COVID-19) vaccine for at risk groups, and this is being offered about 6 months after the last coronavirus vaccine.

Financial Implications

Financial implications and sustainability are being considered within the overall remobilisation agenda working closely with Scottish Government colleagues. The Finance Report is a standing item on the Performance & Resources Committee and Forth Valley NHS Board meeting agendas.

Financial Breakeven is detailed on the Strategic Risk Register as a Very High risk for NHS Forth Valley. As such it is reviewed and managed as a risk assigned to the Performance & Resources Committee.

- SRR.005: Financial Breakeven - If NHS Forth Valley financial plans are not aligned to strategic plans and external drivers of change, there is a risk that our cost base for our services over the medium to long term could exceed our future funding allocation, resulting in an inability to achieve and maintain financial sustainability, and a detrimental impact on current/future service provision.

Workforce Implications

Overarching workforce plan in place to support remobilisation plans along with a focus on staff health and wellbeing.

Risk Assessment

Covid-19 remobilisation is noted as a Strategic Risk and as such is considered through the Strategic Risk Register as a risk assigned to the Performance & Resources Committee.

- SRR.012: Covid-19 Remobilisation - If NHS Forth Valley does not deliver an effective remobilisation plan in response to Covid-19 there is a risk we fail to manage demand on services and miss opportunities for long term change / improvement.

Discussions are underway with regard to threading the Covid-19 Remobilisation Risk through all relevant Strategic Risks in support of establishing a 'norm' going forward.

In terms of performance there are also direct links to SRR.002 Unscheduled Care and SRR.004 Scheduled Care. The Strategic Risk Register Update is a regular item at the NHS Board and will be presented at Agenda Item 6.4.

Relevance to Strategic Priorities

Re-mobilise, Recover, Re-design: The Framework for NHS Scotland, published on 31 May 2020, continues to provide the over-arching context for our remobilisation planning, including the principles and objectives for safe and effective mobilisation.

The draft Remobilisation Plan version 4 was submitted to the Scottish Government along with a number of supporting documents on 7 October 2021. The purpose was to provide an opportunity to review and update our System-Wide Remobilisation Plan 3 to ensure that it continues to reflect the situation, six months into 2021/2022. John Burns, NHS Scotland Chief Operating Officer wrote to the Chief Executive on 19 November 2021 highlighting that he was content for the Plan to be taken through local governance processes. The System-Wide Remobilisation Plan October 2021 to March 2022 was approved by the NHS Board on 30 November 2021 and published on the NHS Forth Valley website.

The updated plan informs on-going engagement with Scottish Government colleagues and service leads within NHS Forth Valley. Quarterly progress updates against the delivery of Remobilisation Plan 4 are being requested by the Scottish Government with the quarter 3 update to the end of December 2021 submitted as requested and per guidance received on 9 February 2022. Quarter 4 updated will be requested in April 2022.

It is anticipated that a three year Recovery Plan for 2022 – 2025 will be requested in the summer. This will encompass a relatively high level narrative setting out our key priorities for recovery and transformation within this period, and how these contribute to national priorities, underpinned by a spreadsheet-based Annual Delivery Plan (ADP).

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.

Further to an evaluation it is noted that:

- Paper is not relevant to Equality and Diversity

Consultation Process

The System-Wide Remobilisation Plan has been informed by our senior clinical and non-clinical decision makers in primary and community care, health and social care partnerships, acute hospital and support services, and their service specific mobilisation plans.

The Recovery Scorecard Short Life Working Group, led by the Medical Director, met on 23 August to review the scorecard. The revised Recovery & Performance Scorecard was endorsed by the Performance & Resources Committee. The scorecard will be reviewed in Spring 2022.

Appendices

Appendix 1: Recovery & Performance Scorecard

Scorecard Detail

Target Type	FV - Local target/measure set and agreed by NHS Forth Valley; SG_R - Target/measure set by Scottish Government in relation to remobilisation planning; SG - Target/measure set by Scottish Government
Frequency	Frequency of monitoring in relation to scorecard
Measure	Brief description of the measure
Date	Date measure recorded
Target	Agreed target position
Current Position	As at date
Previous Position	Previous month, week or day dependent on frequency of monitoring
Run Chart	✓ - indicates run chart associated with measure is available
Key to Direction of travel	▲ - Improvement in period or better than target ▼ - Deterioration in period or below target ◄► - Position maintained

Indicator Definitions and Detail

Emergency Department Attendances Mental Health	Attendances at A&E with a cause of injury recorded as Intentional Self Harm
Emergency Department (ED)	Hospital department which typically provides a consultant-led, 24 hour service with full resuscitation facilities and designated accommodation for the reception of emergency patients. Collectively the term Accident and Emergency (A&E) Services includes the following site types: Emergency Departments (EDs); Minor Injury Units (MIU); community A&Es or community casualty
Accident & Emergency (A&E)	departments that are GP or nurse led; Trolleyed areas of an Assessment Unit
Unscheduled Care Definition	Unscheduled care (USC) is sometimes referred to as unplanned, urgent or emergency care, and is care which cannot be planned in advance. This can happen at any time, 24 hours a day, seven days a week.
ED Percentage Compliance	National standard for A&E waiting times is that new and unplanned return attendances at an A&E service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care such as EDs, assessment units, minor injury units, community hospitals, anywhere where emergency care type activity takes place. The measure is the proportion of all attendances that are admitted, transferred or discharged within four hours of arrival. 95% of patients should wait no longer than four hours from arrival to admission, discharge or transfer for A&E treatment.
Number of ED Attendances	Number of ED attendances and a target of 'Reduction' is relevant in relation to capacity and flow.
Emergency Admissions	Admission to a hospital bed following an attendance at an A&E service. November 2021 - NHS Forth Valley has made changes to the measurement which is now in line with the national data sets. Previous definition was local interpretation.
Elective Target	Average weekly projection
New Outpatient Activity	An outpatient is categorised as a new outpatient at his first meeting with a consultant or his representative following an outpatient referral. Outpatients whose first clinical interaction follows an inpatient episode are excluded.
Diagnostics	Waiting times standard is that patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations - Xray, Ultrasound, CT, MRI, Colonoscopy, Upper Endoscopy, Lower Endoscopy, Cystoscopy
Unavailability	Unavailability, for patients without a date for treatment, is a period of time when the patient is unavailable for treatment. Unavailability can be for medical or social reasons
Did Not Attend (DNA)	A patient may be categorised as did not attend (DNA) when the hospital is not notified in advance of the patient's unavailability to attend on the offered admission date, or for any appointment.
Treatment Time Guarantee (TTG)	There is a 12 week maximum waiting time for the treatment of all eligible patients who are due to receive planned treatment delivered on an inpatient or day case basis
Clinical Priority - P1, P2, P3, P4	Applicable to elective TTG patients as part of the implementation of COVID-19 Clinical Prioritisation Framework P1a - Procedure (for surgical patients) or admission (medical patients) needed within 24 hours P1b - Procedure (for surgical patients) or admission (medical patients) needed within 72 hours P2 - Clinical assessment determines procedure (for surgical patients) or admission (medical patients) required within 4 weeks P3 - Clinical assessment determines procedure (for surgical patients) or admission (medical patients) required within 12 weeks P4 - Clinical assessment determines procedure (for surgical patients) or admission (medical patients) may be safely scheduled after 12 weeks
Readmissions	This is the measure of patients readmitted as an emergency to a medical/surgical specialty within 7 days or 28 days of the index admission. Emergency readmissions as a percentage of all admissions. The 18 Weeks RTT is a whole journey waiting time standard from initial referral to the start of treatment. The standard has been determined by the Scottish Government and states that 90.0% of patients should have a completed pathway within 18 weeks.
Psychological Therapy 18 week RTT	The 18 Weeks RTT is a whole journey waiting time standard from initial referral to the start of treatment. The standard has been determined by the Scottish Government and states that 90.0% of patients should have a completed pathway within 18 weeks.
Child & Adolescent Mental Health Services (CAMHS) 18 week RTT	The percentage occupancy is the percentage of average available staffed beds that were occupied by inpatients during the period.
Bed Occupancy	
Average Length of Stay	This is the mean length of stay (in days) experienced by inpatients in FVRH Acute wards, does not include MH or W&C.
Sickness Absence	Hours lost due to sickness absence / total hours available (%)
Absence for Covid-19 reasons	Coronavirus absences are recorded as Special Leave they are not included within the sickness absences figures. Therefore the absence for Covid-19 reasons is hours lost due to Covid-19/ total hours available (%)

Delayed Discharge	A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge, and who continues to occupy the bed beyond the ready for discharge date
Bed Occupancy	The percentage occupancy is the percentage of average available staffed beds that were occupied by inpatients during the period. 85% is the nationally agreed standard supporting optimum flow
Number of deaths death in hospital since start of outbreak	Cumulative number of deaths in hospital since the start of the outbreak
Number of deaths since start of outbreak - all locations	Weekly provisional figures on deaths registered where coronavirus (COVID-19) was mentioned on the death certificate in Scotland. Figures are based on date of registration. Week runs from Monday to Sunday. Locations include Care Home, Home/non-institution, Hospital, Other institution e.g prison
Hospital staff testing	The number of eligible staff tested in specilaist cancer wards.
Care Home Testing - Staff	Recording of the number of staff tested against the number of staff eligible and available for testing as a percentage – Only staff who are at work in the care home should be included and those staff who are not at work for any reason should be excluded from this number e.g. annual leave, sick leave, days off, self-isolating or working elsewhere.
Index Case	The first documented case in a group of related cases or potential cases.
Flu Vaccinations	The number carried out as a percentage of the eligible cohort. The target is described as the estimated take up rate as a percentage
COVID Vaccination Programme	The percentage of the number eligible for the vaccine vaccinated with 1st dose and 2nd dose

Key Performance Issues

Unscheduled Care

Overall compliance with the 4 hour target in February 2022 was 76.1%; Minor Injuries Unit 99.9%, Emergency Department 67.1%. A total of 1458 patients waited longer than the 4 hour target across both the ED and Minor Injuries Unit (MIU); with 133 waits longer than eight hours and 15 waits longer than 12 hours. The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 990 patients, an increase from 719 in January. Note that this is as a result of issues in relation to flow through the system and system-wide pressures. Wait for a Bed accounted for 136 patients waiting beyond 4 hours with Clinical Reasons accounting for 130 breaches. This is an improvement from the January position of 245 and 147 respectively.

The weekly position is detailed in the Recovery Measures with graph U1 & U2 highlighting the position over time in respect of ED attendance and compliance, noting an increasing trend in the number of attendances. 4436 ED attendances were noted in February 2022 compared with 3294 in February 2021. Despite the increasing attendances these have not reached pre-Covid rates with 5016 attendances in February 2020 and 4877 in February 2019. Recovery Graph U3 details the weekly position in terms of the number of patients seen out with the 4 hour waiting time standard noting an increase in the last 2 weeks. The most recent full week figures highlight a drop in compliance, with the 4 hour ED standard 53.0% and the overall Health Board position 65.7%. The position within ED remains challenging with variation in performance continuing. Factors in relation to bed occupancy, length of stay, delayed discharges, and time of discharge continue to impact on flow through ED. Daily meetings are in place to review urgent actions required to improve the system capacity and flow. The focus on patient and staff safety continues.

A comprehensive Unscheduled Care Update was presented to the Performance & Resources Committee on 18 January 2022 led by the Medical Director. Background and context were provided in respect of the current position along with detail of the National unscheduled care workstreams of Redesign of Urgent Care, Interface and Discharge without Delay. Also described was the programme of redesign being undertaken as part of NHS Forth Valley’s plan to improve the unscheduled care performance through a series of three programmes; Access, Optimise Flow and Transfer. The programmes are aligned to key drivers and to an overarching vision of ‘Transforming Our Care’. The Access programme will see the Emergency Department reviewed in its totality including pathways into and out of ED. Key 30, 60, 90 day actions are in place to support transformation.

A further update will be presented to the Performance & Resources Committee in October 2022.

Scheduled Care

NHS Forth Valley, in line with the rest of NHS Scotland, continues to prioritise and treat those patients most in need of surgery with the application of clinical prioritisation to support appropriate, timely and safe care - Priority level 1a - Procedure (for surgical patients) or admission (medical patients) needed within 24 hours; Priority level 1b - Procedure (for surgical patients) or admission (medical patients) needed within 72; Priority level 2 - Clinical assessment determines procedure (for surgical patients) or admission (medical patients) required within 4 weeks; Priority level 3 - Clinical assessment determines procedure (for surgical patients) or admission (medical patients) required within 12 weeks; Priority level 4 - Clinical assessment determines procedure (for surgical patients) or admission (medical patients) may be safely scheduled after 12 weeks.

At the end of February 2022, the number of patients on the waiting list waiting for a first outpatient appointment reduced to 15,403 from 15,590 the previous month; of which 7,218 were waiting beyond 12 weeks. 53.1% of patients were waiting less than 12 weeks for a first appointment, this is slightly better the previous month. Activity against the agreed Remobilisation Plan trajectory highlights the cumulative position from April 2021 to February 2022 as 96% compliance. Compliance against the plan for the month of February is 102%

In February 2022, the number of inpatients/daycases waiting increased from 3,648 to 3921 with an increase in those waiting beyond 12 weeks to 1,785 from 1,657. Activity against the agreed Remobilisation Plan trajectory highlights the cumulative position from April 2021 to February 2022 as 82% compliance. Compliance against the plan for the month of February is 71%. The reduced activity is as a result of the decision made in January to postpone a number of non-urgent operations in a bid to reduce pressure across the Forth Valley Royal Hospital site and to free up staff to support critical health services. The action was taken in response to a significant increase in Covid-19 infections which had resulted in a high number of staff absences and added to existing service pressures. Note that activity recommenced in February 2022.

Diagnostics

Imaging

At the end of February 2022, 2063 patients were waiting beyond the 6 week standard for imaging which is 65.1% compliance and an improvement from the previous month. Activity against the agreed Remobilisation Plan trajectory highlights the cumulative position from April 2021 to February 2022 as 105% compliance. The position for February 2021 is 104% compliance. Patients continue to be seen on a priority basis with waiting lists actively monitored and managed. Following a significant increase in the numbers of imaging referrals, particularly for CT and Ultrasound, the department continues to work to increase activity and address the long waiters. Note that referrals are in respect of outpatients, inpatients, and the Emergency Department

Endoscopy

At the end of February 2022, 270 patients were waiting beyond 6 weeks for endoscopy with 55.0% compliance and an improvement from the previous month. Activity against the agreed Remobilisation Plan trajectory highlights the cumulative position from April 2021 to February 2022 as 108% compliance with the position in January 106% compliance against plan. The total number of patients waiting for endoscopy has remained relatively static over the last 5 month period.

Cancer

Urgent elective outpatient, daycase and inpatient services to support suspected cancer presentations continue with robust monitoring in place in relation to additions to the 62 day and 31 day cancer pathways. The number of patients being tracked on the 62-day cancer pathway is increasing with approximately 1410 patients tracked at this time of which 9% are confirmed cancer patients.

The January 2021 position is noted as:
-62-day target – 76.4% which is a drop in performance from the December position of 80.5%. The Scotland position is noted as 76.2%
-31-day target – 94.1%. This is the first time compliance has dropped below 95% since January 2019. The Scotland position is 95.9%.

The position for the October to December 2021 quarter is that 79.8% of patients were treated within 62 days of referral with a suspicion of cancer. This is noted to be a decrease from the previous quarter. During the same period, 98.6% of patients were treated within 31 days of the decision to treat.

The Performance & Resources Committee received a Cancer Services Performance Update in March 2022 detailing the Clinical Governance Routes for Cancer Services and highlighting the Framework for Effective Cancer Management and how this would serve as a benchmarking tool for NHS Forth Valley. The team have agreed to provide a progress update to the Performance & Resources Committee in December 2022.

Unavailability

Monitoring of patient unavailability is an Audit Scotland recommendation and refers to the percentage of outpatient or inpatient/daycase unavailability as a proportion of the total waiting list size.

-Outpatient unavailability in February 2022 was 0.8% of the total waiting list
-Inpatient/daycase unavailability in February 2022 increased slightly to 5.1% from 4.6% in January 2022. The unavailability rate is less than 5.1% for all specialties except for Vascular 19.2%, Pain Management 8.6%, ENT 7.6%, Orthopaedics 6.6 and OMFS 6.4%. Note that the number of patients unavailable in theses specialties is 10 or less with the exception of ENT (21 patients) and Orthopaedics (74 patients). This position is monitored on an ongoing basis.

Did Not Attend (DNA)

The new outpatient DNA rate across acute services in February 2022 is noted as 7.2% which is a further reduction or improvement from the position in January of 7.5%. The Scotland position in January is noted as 7.4%. Variation across specialties continues with rates ranging from 15.1% to 0%. The biggest impact in terms of the number of DNAs can be seen in Ophthalmology 9.5% (74 patients), ENT 9.0% (73 patients), Dermatology 8.8% (53 patients) and General Surgery 5.3% (62 patients).

The return outpatient DNA rate across acute services in February 2022 was 6.0%. There continues to be a high number of DNAs in Dermatology 120 patients (7.2%) and Ophthalmology with 177 patients (6.7%). There are also significant DNAs in Orthodontics and Pre Op.

Work continues in support of a reduction in the number of DNAs, including, centralisation of appointments to ensure a consistent approach to appointing; work to ensure a consistent application of the Access Policy; Outpatient Development Group established reviewing how we communicate with patients and work being undertaken to understand the reasons for non-attendance. In addition, Patient Focussed Booking which has not been in place since the implementation of Trakcare due to a system issue, is being reinstated and is anticipated to have a positive impact on the number of DNAs.

Psychological Therapies

In February 2022, 60.0% of patients started treatment within 18 weeks of referral. This is a reduction from the previous month however better than the performance in February 2021 of 53.8%. The Remobilisation Plan trajectory of 60% was exceeded in December with current performance equal to the plan. Due to a number of challenges with recording and reporting systems activity is thought to be under reported. Work is ongoing to improve these systems and reporting accuracy will improve over the coming months.

In the quarter ending December 2021 the published 18 week referral to treatment standard comparison is Scotland 84.4%; Forth Valley 64.1%.

As one of the Board areas receiving a programme of enhanced support, NHS Forth Valley submitted a comprehensive Psychological Therapies Improvement Plan to the Scottish Government. This provides details of improvement actions, anticipated trajectories and plans for use of the allocation from the Mental Health Recovery & Renewal Fund.

A full programme of improvement actions is in place and includes:
-Use of Netcall to complete a waiting list validation exercise.
-Introduction of Netcall appointment reminders by text.
-Introduction of online therapeutic groups.
-Mainstreaming of Near Me and telephone appointments as long-term options for patients.
-Development of the NHS Forth Valley public website mental health pages to include signposting and access to online packages.
-Continuation of the Primary Care Support Service established during covid, providing rapid access to short-term psychologically informed support.
-A visible focus on staff wellbeing, both because it is the right thing to do and because of the positive impact on recruitment and retention.

Further actions underway are described in the Remobilisation Plan 4 Delivery Plan Template Update.
An update in terms of Psychological Therapies was presented to the Performance & Resources Committee in April 2021 detailing key challenges and actions. A further update is scheduled for August 2022.

Child and Adolescent Mental Health Services (CAMHS)

In February 2022, 71.4% of patients started treatment within 18 weeks of referral. This is an improvement from 58.3% in January 2022 and from 38.2% in February 2021. The remobilisation plan trajectory of 45% was exceeded in December 2021 with current performance better than the plan.

In the quarter ending December 2021 the published 18 week referral to treatment standard comparison is Scotland 70.3%; Forth Valley 57.7%.

Work continues to prioritise urgent referrals for children and young people who have experienced longer waits with the aim of clearing the waiting list backlog by 31 March 2023. The Performance & Resources Committee received a comprehensive update in October 2021 detailing the position in respect of referrals, waiting list and activity along with the complexities involved in the delivery of CAMHS. A further update is scheduled in June 2022.

At end of January, our waiting list for CAMHS was 609.

Choice and Partnership Approach (CAPA) went live at the end of January as planned, with the first phase of our nursing team starting their new CAPA job plan. This allowed 160 letters offering an initial choice appointment, being sent in January to our longest waits. An additional 120 choice appointment letters were sent in February, again to our longest waits. This significant ‘choice appointment’ activity is not reflected in the waiting list immediately but would be within 8 weeks of the initial choice appointment. The CAMHS leadership team, continue to progress CAPA job planning with all clinical staff.

NHS Forth Valley submitted an Improvement Plan to the Scottish Government in September 2021 detailing improvement actions and anticipated trajectories. The improvement work planned, and the implementation of CAPA will have an impact on RTT performance with a reduction in performance anticipated. This is a consequence of the need to tackle the waiting list based on prioritising those waiting longest. The measurement for the teams to determine performance will be the reduction in longest wait and reduction of waiting list.

Workforce

The sickness absence target is 4.0% with NHS Forth Valley working towards a local milestone target of 4.5% agreed at the Staff Governance Committee. Absence remains above the target at 5.63% in January 2022 however is an improvement from the previous month and from 5.76% in January 2021. The 12 month rolling average February 2021 to January 2022 is: NHS Forth Valley 6.06%; Scotland 5.54%.

Coronavirus absences are recorded as Special Leave and are not included within the sickness absences figures. The absence for Coronavirus reasons is noted as 4.15% in January 2022; an increase from 3.32% in December 2021. Total absence for January 2022 is 9.78%, a marginal increase from a total of 9.77% in December 2022.

The management of absence and the improvement of staff wellbeing remain key priorities for NHS Forth Valley. A multidisciplinary improvement programme is on-going along with the establishment of a partnership working group. Support is being provided to staff at work, to staff self-isolating, to staff within the shielding category and to enable home working.

Issues in relation to workforce continue to be examined and discussed at the quarterly Staff Governance Committee.

Delayed Discharges

The weekly delayed discharge position (all delays) is detailed in recovery measure graph V3 under better value and highlights the unstable situation in respect of delays.

The February 2022 census position in relation to standard delays (excluding Code 9 and guardianship) is 60 delays; an increase from 57 in January. There was a total of 31 code 9 and guardianships with 2 infection codes noted. In addition, there were 8 code 100 patients (These patients are undergoing a change in care setting and should not be classified as delayed discharges however are monitored).

The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the February 2022 census was 1622, this is a decrease from 1936 in January. Local authority breakdown is noted as Clackmannanshire 266, Falkirk 694, and Stirling 289. There were a further 373 bed days occupied by delayed discharges for local authorities’ out with Forth Valley.

The reasons for delay (excluding code 9) are noted as:

Clackmannanshire

- 1 – awaiting housing adaptations (over 2 weeks)
- 2 - awaiting care packages for home (1 patient over two weeks and 1 under two weeks)
- 2 – awaiting move to Care Home (2 over two weeks)

Stirling

- 4 – allocated and assessment commenced (2 patients over two weeks and 2 under two weeks)
- 3 - await move to Care Home (3 patients over two weeks)
- 9 - awaiting care packages for home (1 patient over two weeks and 8 under two weeks)
- 1 – awaiting housing adaptations (over 2 weeks)

Falkirk

- 8 - awaiting move to care homes (8 patients are over two weeks)
- 13 - awaiting care packages for home (3 patient over two weeks and 10 under two weeks)
- 14 - allocated and assessment commenced (6 patients over two weeks and 8 under two weeks)
- 1 - awaiting allocation and assessment (under two weeks)
- 1 – awaiting housing adaptations (over 2 weeks)

Significant focus remains on the delayed discharge position to support flow of patients through Forth Valley Royal Hospital and the Community sites. Work is continuing in partnership, including third sector, to ensure appropriate care and to support timely discharge with care in the community, community intermediate care and community hospital facilities a high priority.

Detail of the Health & Social Care Partnership Recovery Planning was presented to the Performance & Resources Committee in January 2022. Actions are in place include enabling the right short term support at home through responsive community care and support, coordination of community support with less duplication and a more efficient support model, Care home multi agency working, interim placements to care homes, third sector link worker based on the acute site and review of Winter Plan template 2021/22, with implementation of agreed actions. A number of further supporting actions are being developed.

Test & Protect

The Test and Protect Service continues to work well linking with health protection who manage the more complex cases.

We continue to ensure that the prerequisite number of staff is available daily working to support timely contact with the use of a shorter script for Contact Tracers to work through and Text Messaging to inform contacts. The service remains busy with the number of cases last week 5,533. Of note is that routine contact tracing will end on 30 April 2022.

Week beginning Individual Cases (PHS)

14 February 2022 - 3259

21 February 2022 - 2435

28 February 2022 - 3915

07 March 2022 - 5934

14 March 2022 - 5533

A high level of compliance continues with staff and care home testing:

- Care home testing 89.1%
- Staff Testing – cancer services – 100%

Covid-19 Vaccination

The Covid-19 vaccination programme continues in line with Scottish Government guidance and Joint Committee on Vaccination and Immunisation (JCVI) recommendations. The programme continues to be delivered along with the Covid-19 booster programme taking account of guidance received.

The JCVI advise a spring dose of the coronavirus (COVID-19) vaccine for:

- Adults aged 75 years and over (or will turn 75 by 30 June 2022)
 - Residents in care homes for older adults
 - Individuals aged 12 years and over who have a weakened immune system
- and this is being offered about 6 months after the last coronavirus vaccine.

A full vaccination programme update was presented to the Performance & Resources Committee in January 2022 detailing progress with the Vaccination Transformation Programme, the Covid vaccination programme and uptake rates

KEY RECOVERY MEASURES

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BETTER WORKFORCE

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BETTER VALUE

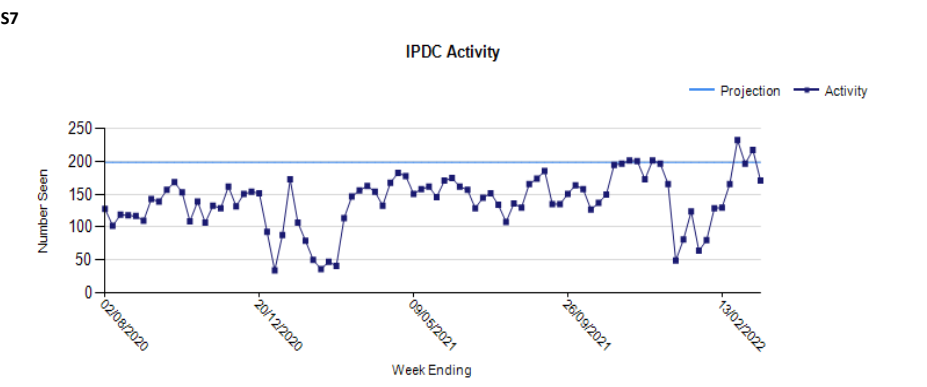
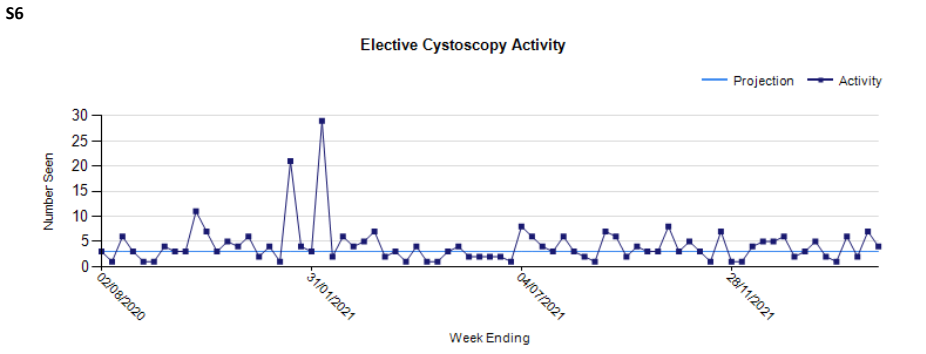
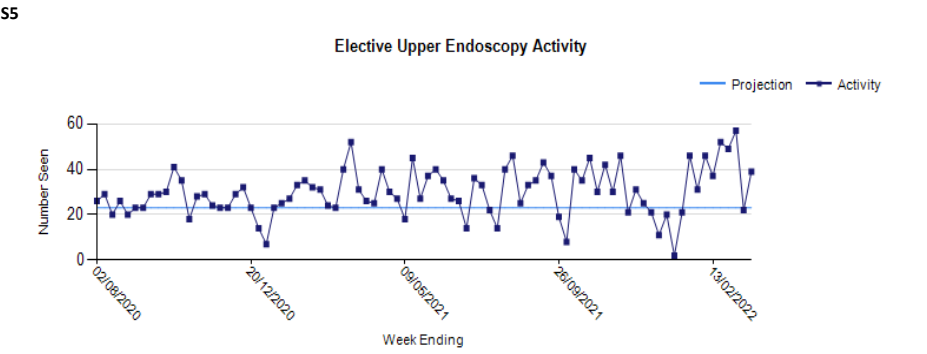
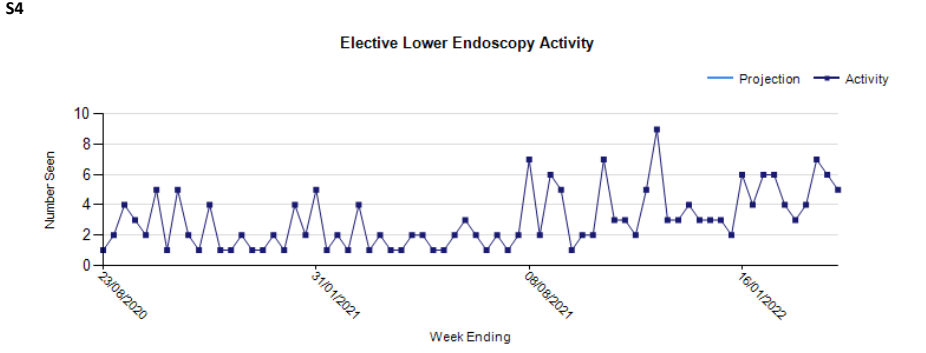
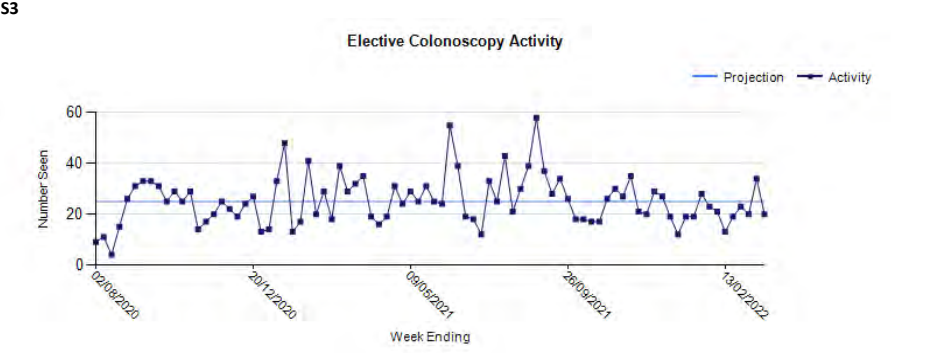
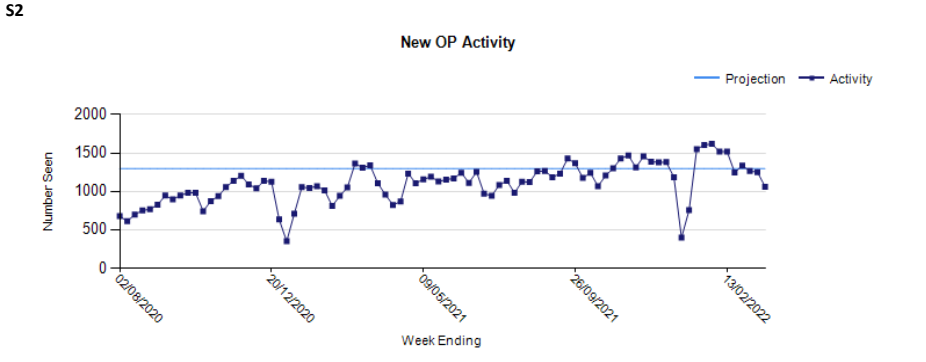
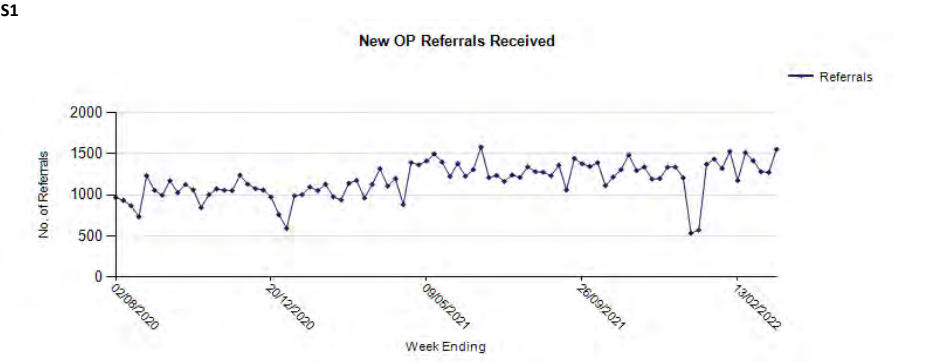
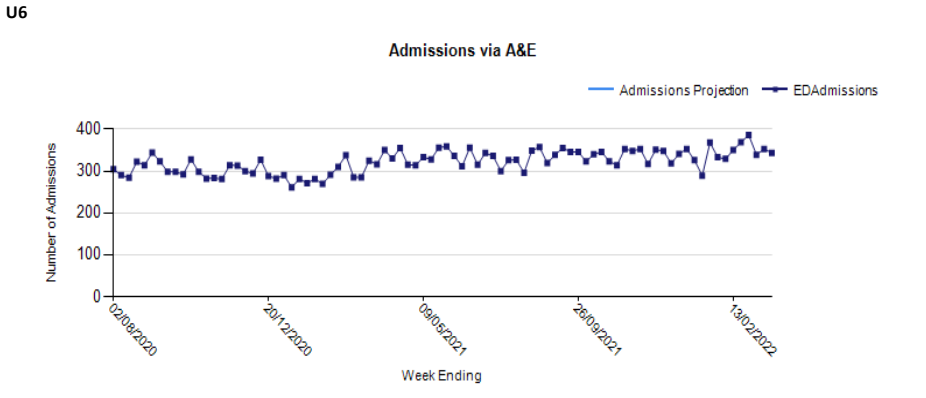
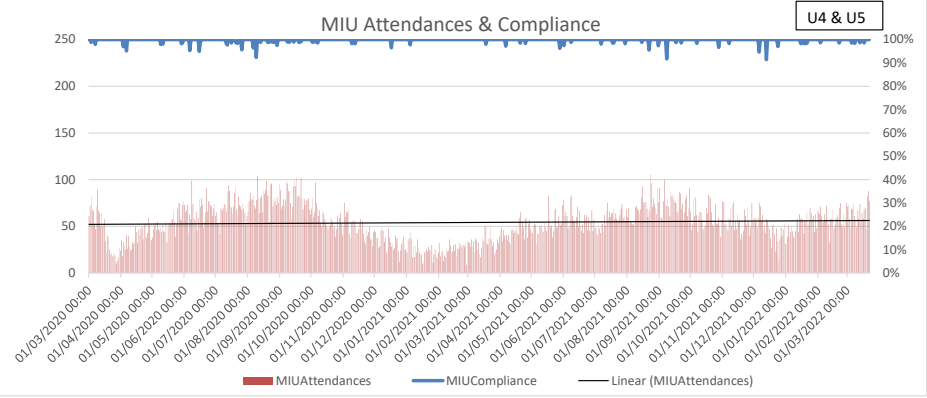
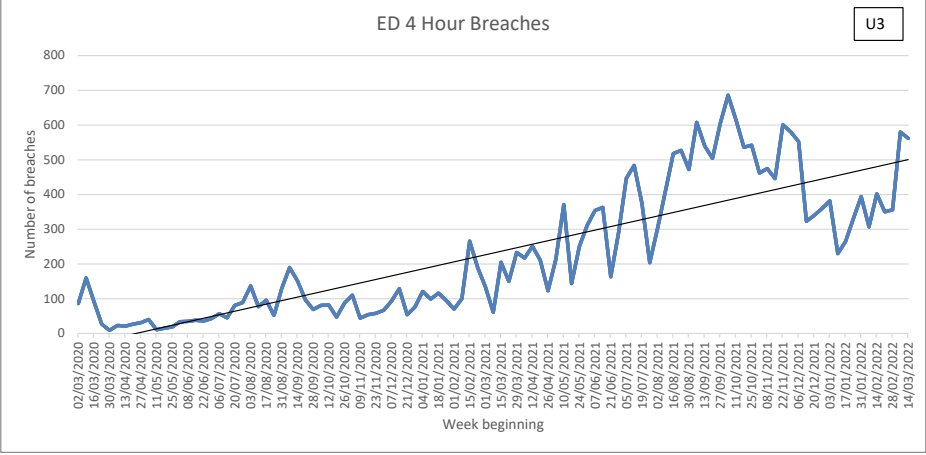
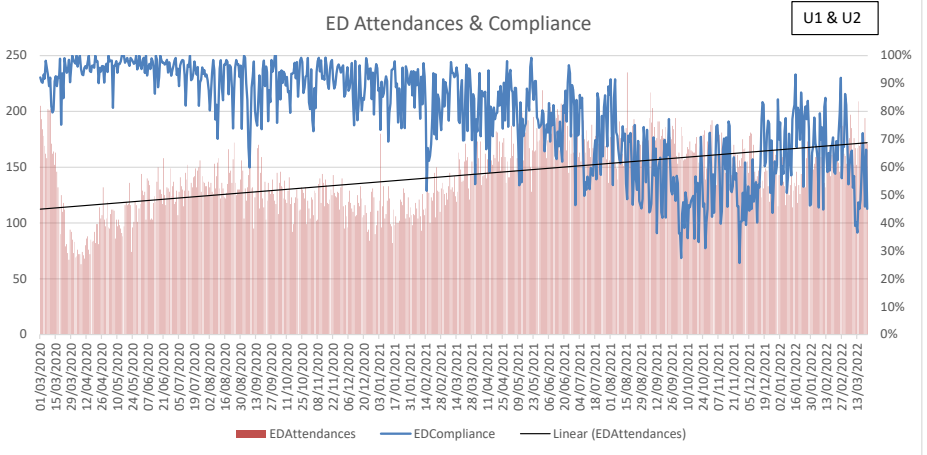
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FINANCE

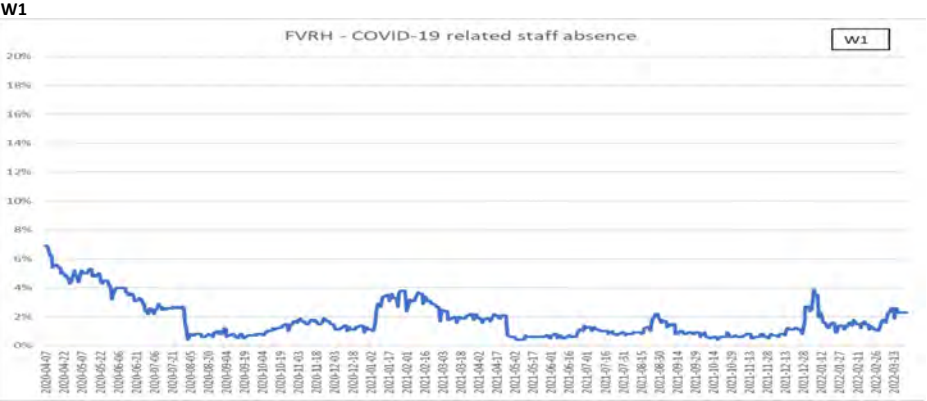
Regular and comprehensive updates provided by Director of Finance at System Leadership Team, Performance & Resources Committee and the NHS Board

RECOVERY GRAPHS

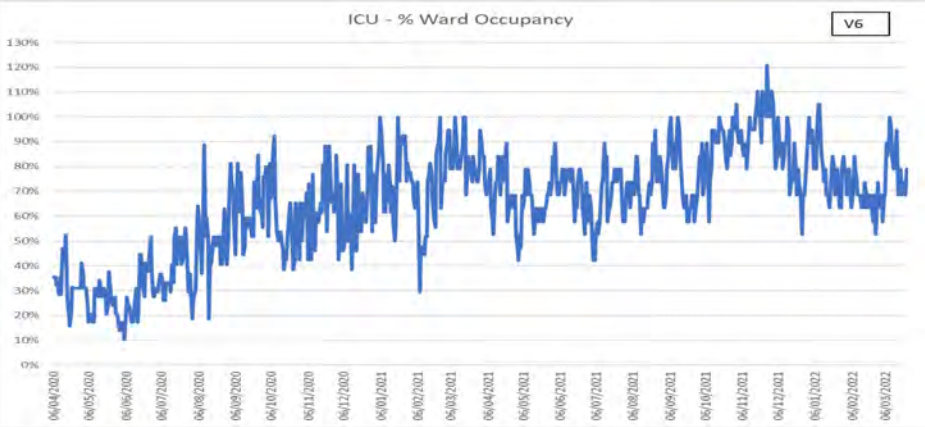
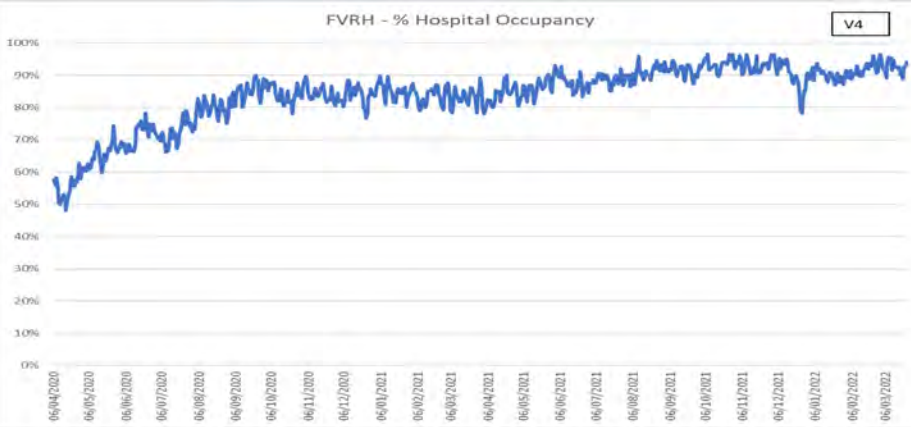
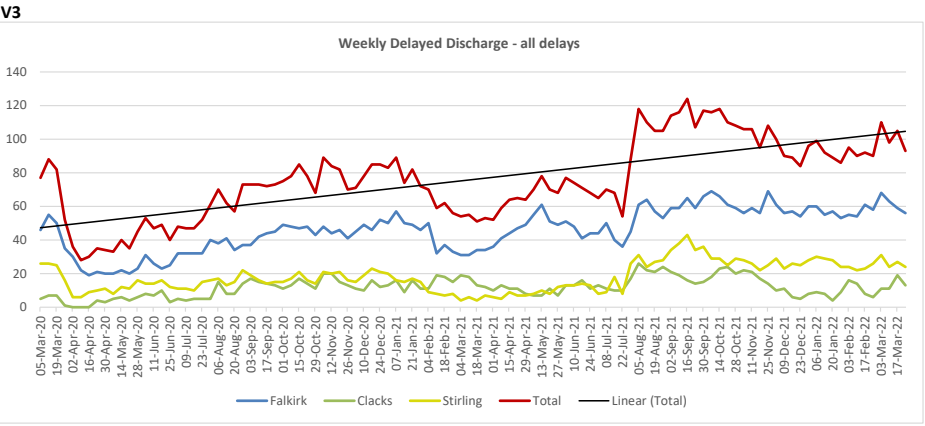
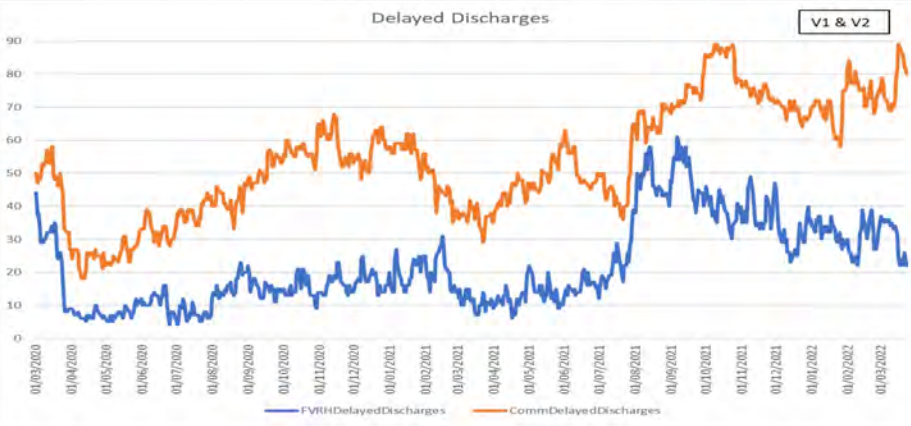
Better Care



Better Workforce



Better Value

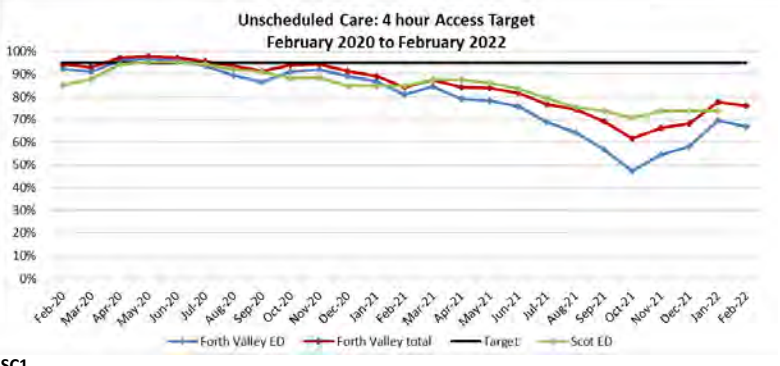


KEY PERFORMANCE MEASURES COVID-19

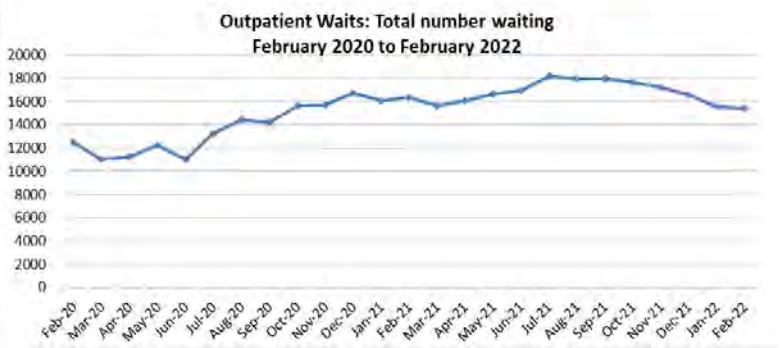
BETTER CARE									
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	RUN CHART	DIRECTION OF TRAVEL
UNSCHEDULED CARE									
US1	FV	Monthly	Number of ED attendances - Mental Health	28-Feb-22	-	72	117	-	-
US2	FV	Monthly	Emergency Department % compliance against 4 hour access target - Mental Health	28-Feb-22	95%	55.6%	55.6%	-	◀▶
US3	SG	Monthly	Emergency Department % compliance against 4 hour access target	28-Feb-22	95%	67.1%	69.5%	✓	▼
US4	SG	Monthly	NHS Forth Valley Overall % compliance against 4 hour target	28-Feb-22	95%	76.1%	77.6%	✓	▼
US5	SG	Monthly	Minor Injuries Unit % compliance against 4 hour target	28-Feb-22	95%	99.9%	99.8%	-	▲
SCHEDULED CARE									
Outpatients									
SC1	SG	Monthly	Total Number of New Outpatients Waiting	28-Feb-22	Reduction	15,403	15,590	✓	▲
SC2	SG	Monthly	Number of New Outpatients waiting over 12 weeks	28-Feb-22	Reduction	7,218	7,462	✓	▲
SC4	Audit	Monthly	Outpatient Unavailability	28-Feb-22	Monitor	0.8%	0.7%	✓	▼
SC5	FV	Monthly	New Acute Services Outpatient % DNA	28-Feb-22	5%	7.2%	7.5%	-	▲
	FV	Monthly	Return Acute Services Outpatient % DNA	28-Feb-22	5%	6.0%	5.9%	-	▼
Diagnostics									
SC6	SG	Monthly	Percentage waiting less than 42 days - Imaging	28-Feb-22	100%	65.1%	60.4%	✓	▲
		Monthly	Number waiting beyond 42 days - Imaging	28-Feb-22	0	2063	2222	-	▲
SC7	SG	Monthly	Percentage waiting less than 42 days - Endoscopy	28-Feb-22	100%	55.0%	44.7%	✓	▲
		Monthly	Number waiting beyond 42 days - Endoscopy	28-Feb-22	0	270	329	-	▲
Cancer									
SC8	SG	Monthly	62 Day Cancer Target - Percentage compliance against target	31-Jan-22	95%	76.4%	80.5%	✓	▼
	SG	Monthly	62 Day Cancer - Number seen within target against total	31-Jan-22	-	55/72	62/77	-	-
SC9	SG	Monthly	31 Day Cancer Target - Percentage compliance against target	31-Jan-22	95%	94.1%	98.9%	✓	▼
	SG	Monthly	31 Day Cancer Target - Number seen within target against total	31-Jan-22	-	80/85	90/91	-	-
SC10	SG	Quarterly	62 Day Cancer Target - Percentage compliance against target	31-Dec-21	95%	79.8%	82.1%	✓	▼
SC11	SG	Quarterly	31 Day Cancer Target - Percentage compliance against target	31-Dec-21	95%	98.6%	97.2%	✓	▲
Inpatients & Day cases									
SC12	SG	Quarterly	Number of patients that waited >12 weeks - Completed Wait	31-Dec-21	0	956	771	-	-
	SG	Quarterly	% Compliance with 12 week TTG Standard	31-Dec-21	100%	51.9%	59.7%	-	-
SC13	SG	Monthly	Total Number of Inpatients/Day cases Waiting	28-Feb-22	Reduction	3,921	3,648	✓	▼
SC14	SG	Monthly	Number of Inpatients/Day cases waiting over 12 weeks	28-Feb-22	Reduction	1,785	1,657	✓	▼
SC15	Audit	Monthly	Inpatient/Day case Unavailability	28-Feb-22	Monitor	5.1%	4.6%	✓	▼
Readmissions									
R1	FV	Monthly	Readmissions - Surgical 7 day	28-Feb-22	-	3%	3%	-	◀▶
	FV	Monthly	Readmissions - Surgical 28 day	28-Feb-22	-	6%	6%	-	◀▶
	FV	Monthly	Readmissions - Medical 7 day	28-Feb-22	-	1%	1%	-	◀▶
	FV	Monthly	Readmissions - Medical 28 day	28-Feb-22	-	4%	4%	-	◀▶
MENTAL HEALTH									
MH1	SG	Monthly	Psychological Therapies - 18 week RTT compliance	28-Feb-22	90%	60.0%	65.9%	✓	▼
MH2	SG	Monthly	Child & Adolescent Mental Health Services - 18 week RTT compliance	28-Feb-22	90%	71.4%	58.3%	✓	▲
BETTER WORKFORCE									
REF		FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	RUN CHART	DIRECTION OF TRAVEL
WF1	SG	Monthly	Overall Absence	31-Jan-22	4.5%	5.63%	6.45%	✓	▲
WF2	SG_R	Monthly	COVID-19 related absence - number of employees	31-Jan-22	-	1121	1097	-	▼
WF3	FV	Monthly	Absence for Covid-19 reasons	31-Jan-22	-	4.15%	3.32%	✓	▼
BETTER VALUE									
REF		FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	RUN CHART	DIRECTION OF TRAVEL
VA1	FV	Monthly	Delayed Discharges - excl. Code 9 & Guardianship (Standard Delays)	28-Feb-22	Reduction	60	57	✓	▼
			Falkirk	28-Feb-22	Reduction	36	29	✓	▼
			Clackmannanshire	28-Feb-22	Reduction	5	7	✓	▲
			Stirling	28-Feb-22	Reduction	17	18	✓	▲
			Outwith Forth Valley	28-Feb-22	Reduction	2	3	✓	▲
VA2	FV		Code 9 & Guardianship Delays	28-Feb-22	Reduction	31	31	✓	◀▶
			Falkirk	28-Feb-22	Reduction	21	22	✓	▲
			Clackmannanshire	28-Feb-22	Reduction	1	0	✓	▼
			Stirling	28-Feb-22	Reduction	7	7	✓	◀▶
			Outwith Forth Valley	28-Feb-22	Reduction	2	2	✓	◀▶
VA3	FV		Total Bed Days Occupied by Delayed Discharges	28-Feb-22	Reduction	1622	1936	✓	▲
			Falkirk	28-Feb-22	Reduction	694	601	✓	▼
			Clackmannanshire	28-Feb-22	Reduction	266	173	✓	▼
			Stirling	28-Feb-22	Reduction	289	760	✓	▲
			Outwith Forth Valley	28-Feb-22	Reduction	373	402	✓	▲
VA4	FV	Monthly	FVRH Acute Wards Average Length of Stay (Days)	28-Feb-22	Reduction	6.56	7.17	-	▲
Finance									
Regular and comprehensive updates provided by Director of Finance at System Leadership Team, Performance & Resources Committee and the NHS Board									

MONTHLY KEY PERMANCE GRAPHS

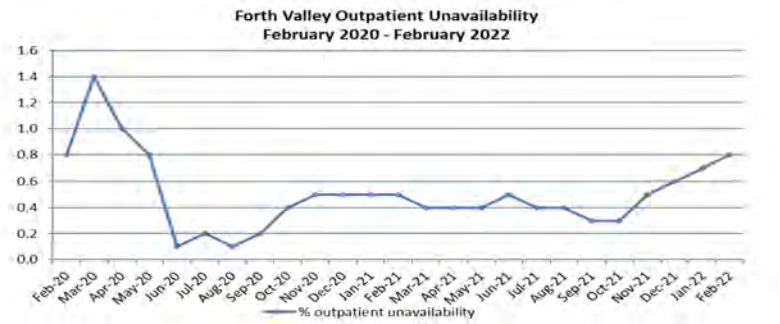
Better Care
US3 & 4



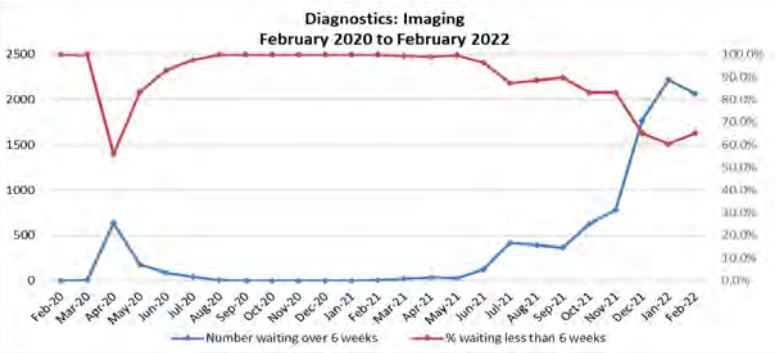
SC1



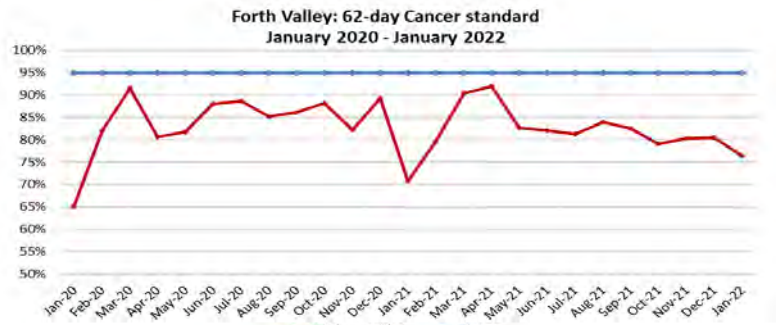
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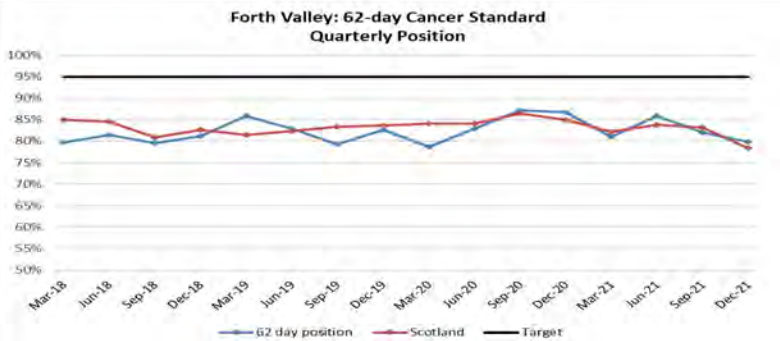
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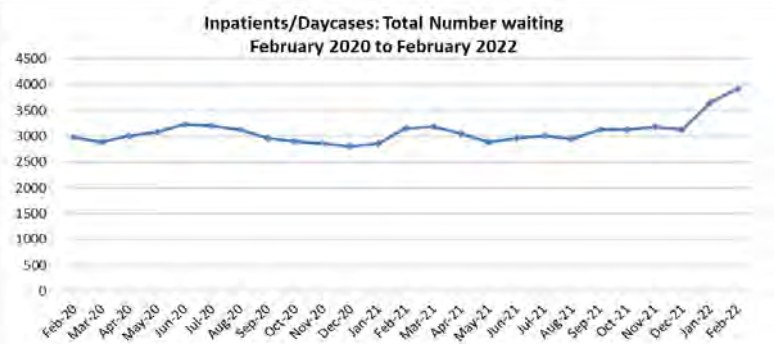
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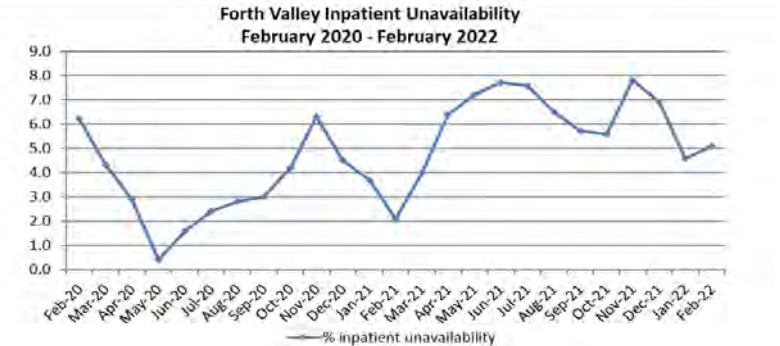
SC10



SC13

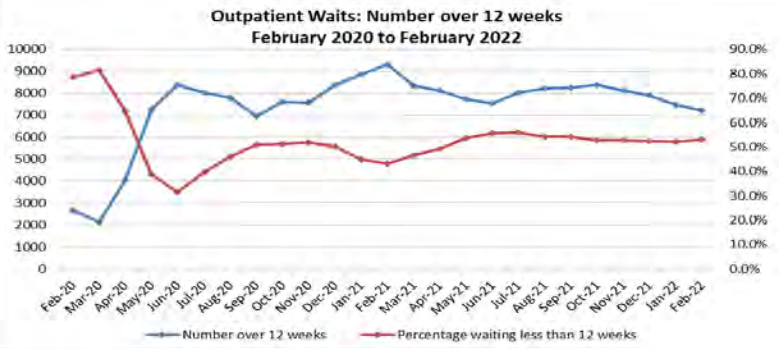


SC15

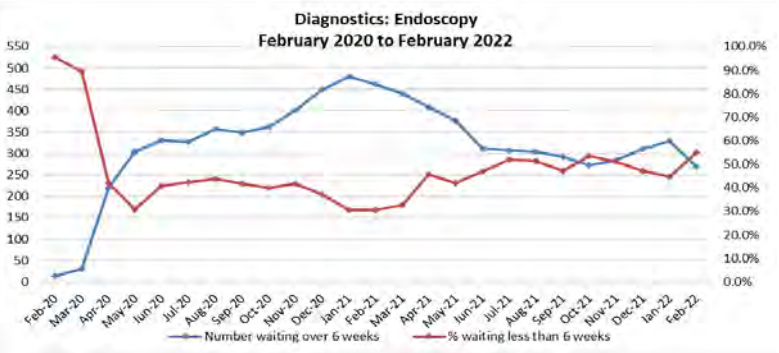


MH1

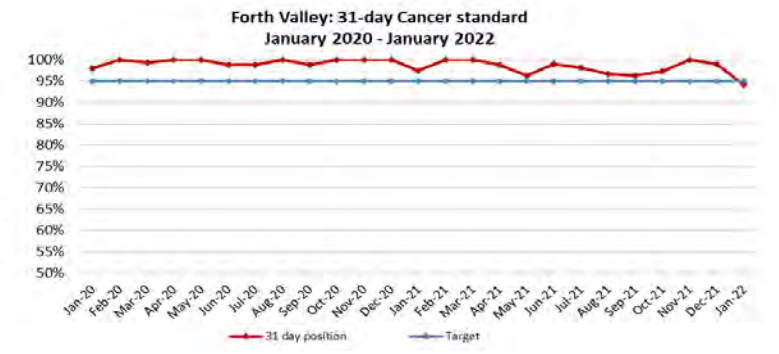
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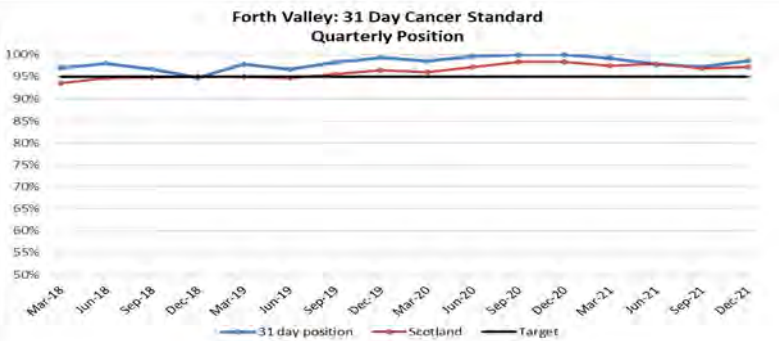
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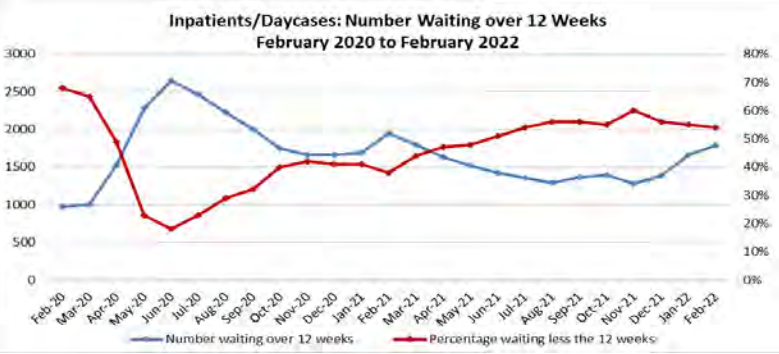
SC9



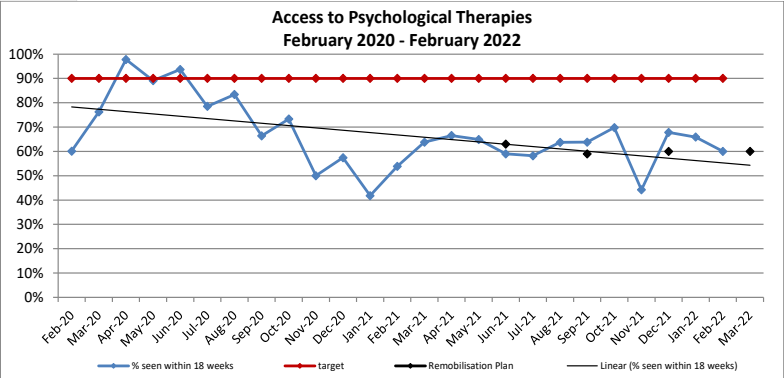
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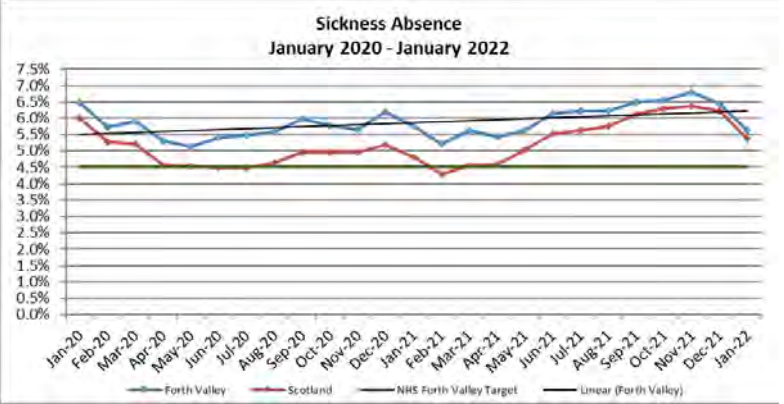
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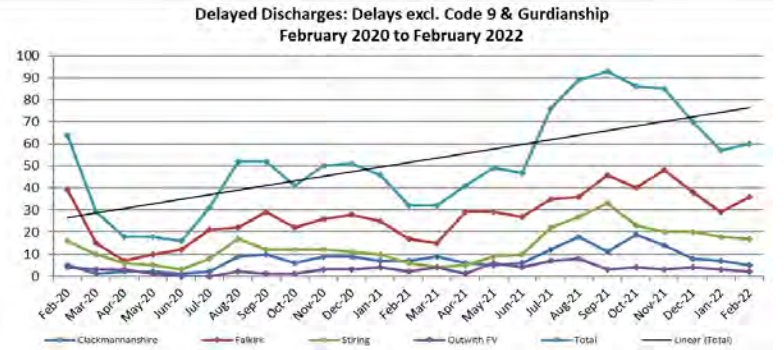
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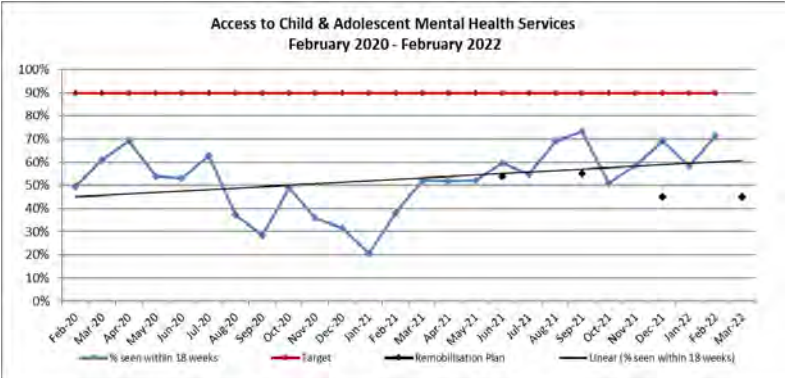
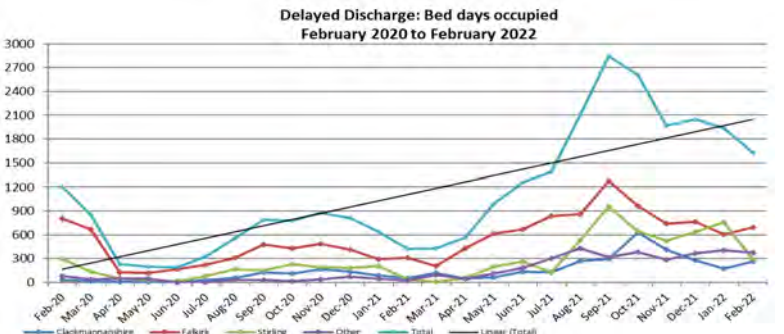
WF1



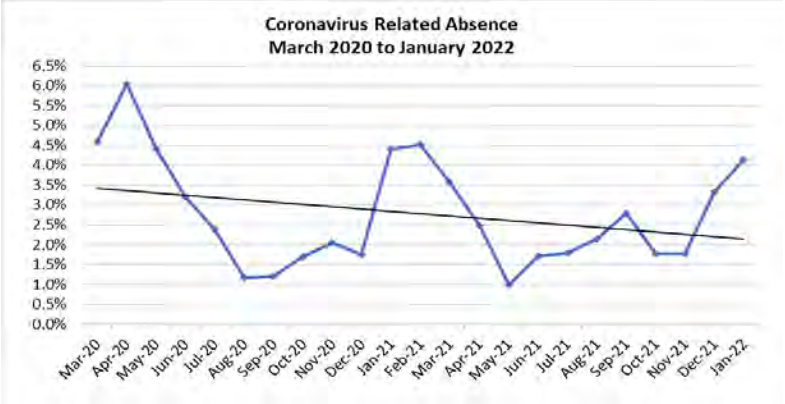
VA1



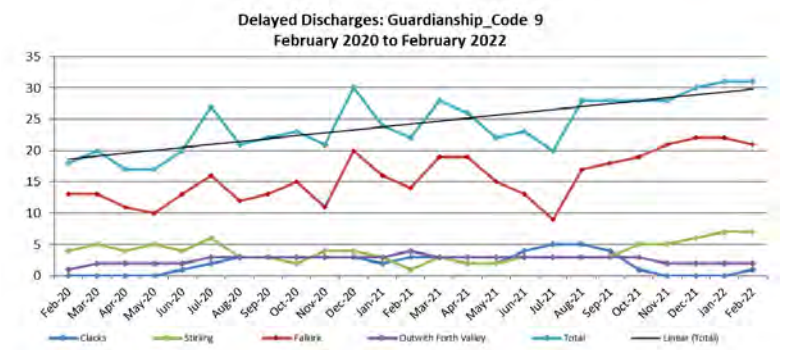
VA3



WF3

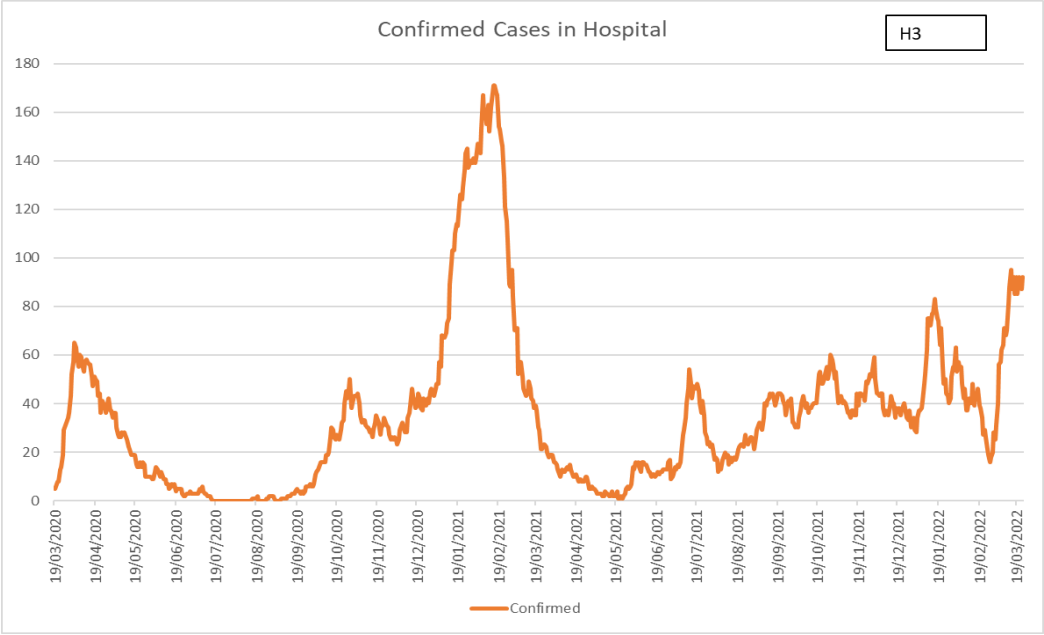
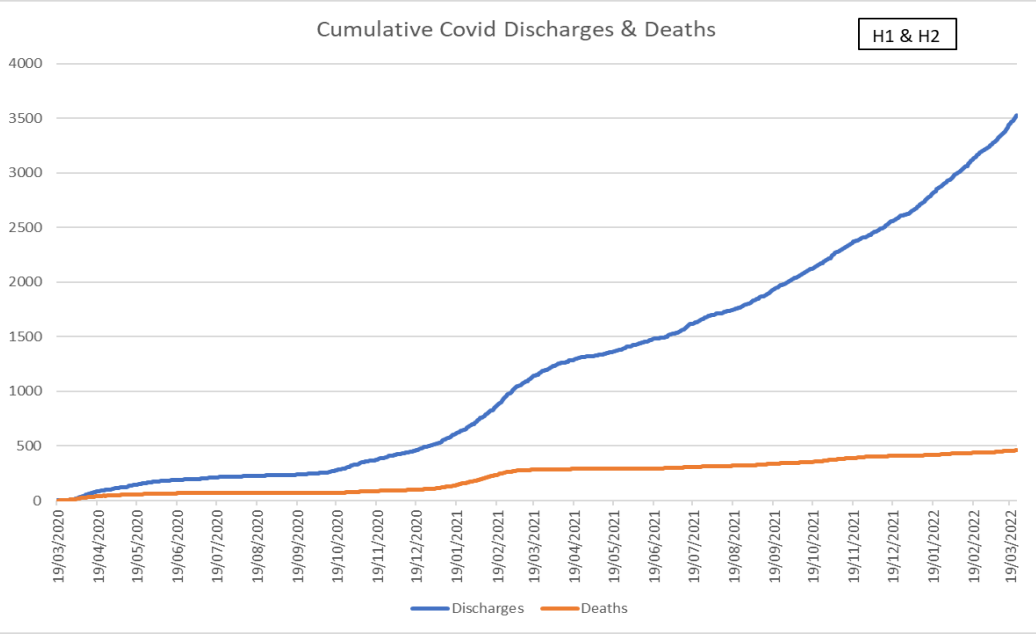


VA2



KEY RESPONSE MEASURES COVID-19

BETTER HEALTH									
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	RUN CHART	DIRECTION OF TRAVEL
H1	FV	Daily	Number of deaths in hospital since start of outbreak	24-Mar-22	-	463	454	✓	-
H2	FV	Weekly	Number of deaths since start of outbreak by local authority - total	14-Mar-22	-	820	817	-	-
			Number of deaths since start of outbreak by local authority						
		Weekly	Falkirk	14-Mar-22	-	449	446	-	-
		Weekly	Clackmannanshire	14-Mar-22	-	152	152	-	-
		Weekly	Stirling	14-Mar-22	-	219	219	-	-
H3	FV	Weekly	Number of new confirmed COVID-19 patients in hospital	14-Mar-22	Decrease	159	152	✓	▼
H4	FV	Weekly	Number of confirmed COVID-19 cases in hospital over the 7 day period	14-Mar-22	Decrease	206	171	-	▼
H5	FV	Weekly	Number of confirmed COVID-19 cases ICU over the 7 day period	14-Mar-22	Decrease	8	6	-	▼
H6	FV	Weekly	Number of COVID-19 positive patients ventilated over the 7 day period	14-Mar-22	Decrease	1	1	-	◀▶
H7	FV	Weekly	Total number of patients ventilated over the 7 day period	14-Mar-22	-	8	13	-	▲
Test & Protect									
T1	SG	Weekly	Staff Testing Numbers - Cancer	24-Mar-22	-	100.0%	100.0%	-	◀▶
T2	SG	Weekly	Care Home Testing - Staff - Total	21-Feb-22	70%	89.1%	99.9%	-	▼
			Care Home Testing - staff - by Partnership						
		Weekly	Falkirk	21-Feb-22	-	97.5%	105.1%	-	▼
		Weekly	Clackmannanshire and Stirling	21-Feb-22	-	84.4%	96.3%	-	▼
T3	SG	Weekly	Contact Tracing - unique contacts within Health Board	14-Mar-22	-	5533	5934	-	-
T4	SG	Weekly	Percentage of Index Cases reached within 24 hours	14-Mar-22	-	95.6%	93.4%	-	-
T5	SG	Weekly	Percentage of Index Case interviewed to complete within 24 hours	14-Mar-22	-	95.7%	93.9%	-	-
COVID Vaccination Programme - Percenatge of number eligible vaccinated						1st Dose		2nd Dose	
						24-Mar-22	17-Mar-22	24-Mar-22	17-Mar-22
CV1	SG	Weekly	Age 80 and over	24-Mar-22	-	99%	99%	97%	97%
CV2	SG	Weekly	Age 75 to 79	24-Mar-22	-	102%	102%	101%	101%
CV3	SG	Weekly	Age 70 to 74	24-Mar-22	-	103%	103%	103%	103%
CV4	SG	Weekly	Age 65 to 69	24-Mar-22	-	97%	97%	96%	96%
CV5	SG	Weekly	Age 60 to 64	24-Mar-22	-	102%	102%	102%	102%
CV6	SG	Weekly	Age 55 to 59	24-Mar-22	-	101%	101%	100%	100%
CV7	SG	Weekly	Age 50 to 54	24-Mar-22	-	95%	95%	94%	94%
CV8	SG	Weekly	Age 40 to 49	24-Mar-22	-	90%	90%	88%	88%
CV9	SG	Weekly	Age 30 to 39	24-Mar-22	-	90%	90%	86%	86%
CV10	SG	Weekly	Age 18 to 29	24-Mar-22	-	82%	82%	77%	77%
CV11	SG	Weekly	Age 16 to 17	24-Mar-22	-	90%	90%	72%	71%
CV13	SG	Weekly	Total	24-Mar-22	-	93%	93%	91%	90%
CV12	SG	Weekly	Age 12 to 15	24-Mar-22	-	77%	77%	53%	52%
Note that individuals may fall into more than one of the cohorts below									
CV15	SG	Weekly	At highest risk clinically extremely vulnerable	24-Mar-22	-	97%	97%	96%	96%
CV16	SG	Weekly	Unpaid carer	24-Mar-22	-	95%	95%	93%	93%
PPE									
Weekly update received. Currently no issues however the position will be kept under review									
CRITICAL MEDICINES									
Daily update however currently no issues. The position will be kept under review									



FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

7.4 Whistleblowing Standards and Activity Report For Assurance

Executive Sponsor: Professor Angela Wallace

Author: Professor Angela Wallace, Executive Nurse Director and
Ms Claire Peacock, PA to Executive Nurse Director / Whistleblowing Officer

Executive Summary

The new National Whistleblowing Standards were launched on 1 April 2021 and a significant amount of work is underway to ensure that the standards are implemented across NHS Forth Valley.

This paper is presented to the NHS Board to provide an update on the implementation of the Whistleblowing Standards and the Whistleblowing activity in NHS Forth Valley for Quarter 3 (Q3).

Recommendation

The Forth Valley NHS Board is asked to: -

- **note** that the full implementation of the National Whistleblowing Standards across NHS Forth Valley.
- **note** Whistleblowing activity in NHS Forth Valley in Quarter 3 of 2021/22

Key Issues to be Considered

1. Purpose of the Paper

This paper is presented to the NHS Board to provide an update on the implementation of the Whistleblowing Standards and the Whistleblowing activity in NHS Forth Valley.

- 1.1 As detailed in the November 2021 update the Whistleblowing Implementation Group continued to progress with the milestones to deliver the key elements of the delivery plan. There has been a wide range of ongoing activity in this reporting period (Q3).

2. Position

- 2.1 During 2021 communication regarding the standards was shared widely across Health and Social Care Partnerships and Key Contractors and furthermore an NHS website was designed to include initial communications including signpost to national work.
- 2.2 To support system implementation a generic email and phone line was put in place and was made live, monitored by the Whistleblowing Liaison Officer. In addition a freedom to speak section was added to safeguard and a plan was made for the system to go live during the full launch of the standards across NHS Forth Valley.
- 2.3 A staff guide containing NHS Forth Valley's local processes and procedures was developed and includes confidential contacts and raising awareness of the suite of training programmes and support for staff across the Whistleblowing Standards.

2.4 Communication regarding the TURAS learn training programmes was shared locally across Health and Social Care Partnerships via the intranet and NHS Forth Valley website and work continues to identify the cohort of staff that are required to complete the training developed by INWO (*1 hour module for staff and 3 hour module for managers*).

2.5 During this quarter (Q3) work continued across NHS Forth Valley to fully implement the national Whistleblowing Standards. The guide, which sets out the local procedures for raising a concern under the national Whistleblowing Standards, is now available on the intranet and [NHS Forth Valley website](#) and in turn has been shared with our key contractors for wider distribution. The guide includes details of the local arrangements, contacts and procedures in place – *refer to Appendix 1*.

2.6 A key focus of the WBIG & WBOG is to now build into our approach an ongoing impact evaluation and learning system with feedback and improvements captured and shared as its core to build the confidence of the staff in these new standards overtime.

3. Whistleblowing Activity

3.1 The format of this section of the report reflects the Scottish Government's mandate to capture performance of the Board against the 9 Key Performance Indicators (*see Appendix 2*) as outlined in the Whistleblowing Procedure.

Whistleblowing Key Performance Indicators RAG status

The table below provides an overview of the current performance in Quarter 3 against each of the Key Performance Indicators. Further details on each of the indicators are provided throughout the report.

Measure	Status	As at	RAG Status
KPI 1 Learning from Whistleblowing Concerns		Feb-21	
KPI 2 Whistleblowing Procedure Experience		Feb-21	
KPI 3 Self Awareness & Training		Feb-21	
KPI 4 Total Number of Concerns Received	3	Feb-21	
KPI 5 Concerns Closed at Each Stage	2	Feb-21	
KPI 6 Concerns Upheld or Not Upheld	1	Feb-21	
KPI 7 Average Times	0	Feb-21	
KPI 8 Closed in full within the timescales	2	Feb-21	
KPI 9 Number of Cases where an extension is authorised	0	Feb-21	

Key Performance Indicator One: Learning from Whistleblowing Concerns

The Indicator requires NHS Forth Valley to demonstrate any changes or improvements to services or procedures as a result of a Whistleblowing concern.

The learning and improvement identified from the Whistleblowing concern in this quarter included:

Clinical Care
Communication

The undernoted top 3 themes of Whistleblowing concerns received have been identified during this quarter and a brief synopsis of learning from Whistleblowing themes is detailed below:

At this time the activity is too low to extrapolate any meaningful themes at this point. This is consistent across NHS Scotland.

Independent National Whistleblowing Officer (INWO)

If a colleague remains unhappy with the response received from NHS Forth Valley, they have the right to contact the Independent National Whistleblowing Officer (INWO) to request an investigation into their complaint. The INWO is the final opportunity for the colleague in the NHS Whistleblowing Procedure and offers an independent view on whether the NHS has reasonably responded to a Whistleblowing concern.

The INWO has received 1 case relating to NHS Forth Valley Whistleblowing concerns during this quarter (Q3). The table below provides detail of the outcomes as at quarter 2 from the investigations.

2021/22 INWO Outcomes	Total Number
Fully Upheld	0
Partly Upheld	0
Not Upheld	0
No Investigation Conducted	1
Withdrawn	0

Key Performance Indicator Two: Whistleblowing Procedure Experience

The Whistleblowing Procedure requires NHS Forth Valley to gather feedback from the person making the complaint regarding their experience of the process.

To note that a feedback and learning system is planned for later this year, however at this time any individual wishing to have areas considered under the Whistleblowing procedure is supported and followed up in relation to the Whistleblower or their concerns.

Key Performance Indicator Three: Self Awareness and Training

There is a requirement to report on levels of staff perceptions and awareness of training.

In this quarter (Q3) the data is not available, however this section of the report will evolve overtime as the Whistleblowing Standards are launched through-out NHS Forth Valley services.

Key Performance Indicator Four: Total number of Concerns Received

During this quarter (Q3) there was 1 case considered and investigated under Stage 1 of the Whistleblowing procedure. A Senior Manager was identified to look into the concerns raised and a written response was provided within the 5 working day Stage 1 target.

The table below details the number of concerns received to date:

Concerns Type	Number of Concerns	Number of concerns closed at each stage
Stage 1	3	2
Stage 2	0	0
Stage 2 after escalation	0	0

Key Performance Indicator Five: Concerns Closed at Each Stage

The table below details the number of concerns closed at each stage during this quarter:

Concerns Type	Number of concerns closed at each stage
Stage 1	1
Stage 2	0
Stage 2 after escalation	0

Key Performance Indicator Six: Concerns Upheld and Not Upheld

To meet the requirements of Indicator Six, a breakdown of the formal outcome (upheld, partially upheld, or not upheld) against Stage 1 and Stage 2 concerns is provided below:

The table below provides a breakdown of the formal outcome of the total number of concerns closed at Stage 1 for this reporting period:

Stage 1	No. Of Concerns Closed	% of Concerns Closed at Stage 1
Upheld Concerns		
Not Upheld Concerns	2	
Partially Upheld Concerns	1 (under consideration)	100%

The table below provides a breakdown of the formal outcome of the total number of concerns closed at Stage 2 for this reporting period:

Stage 2	No. Of Concerns Closed	% of Concerns Closed at Stage 2
Upheld Concerns	Not applicable	Not applicable
Not Upheld Concerns	Not applicable	Not applicable
Partially Upheld Concerns	Not applicable	Not applicable

Key Performance Indicator Seven: Average Times

A reporting requirement of the Whistleblowing Procedure is to report on the average times in working days to close concerns at each stage and a detailed breakdown is provided in the table below:

	Average Times	Closed Concerns
Stage 1	Not applicable	Not applicable
Stage 2	Not applicable	Not applicable

In this quarter (Q3) there has been minimal activity. This section of the report will continue to be develop overtime dependant on the activity.

Key Performance Indicator Eight: Closed in Full within the Timescales

Overall Whistleblowing Performance

Stage 1 and Stage 2 Performance

During this quarter (Q3), a total of 1 complaint was investigated under Stage 1 of the Whistleblowing Procedure and responded to within the 5 working day target.

A breakdown of the numbers of concerns received and investigated at each stage is detailed in the table and below:

	Acute	Corporate	Mental Health/Learning Disabilities/Prisons	HSCP
Stage 1	0	0	3	0
Stage 2	0	0	0	0
TOTAL	0	0	3	0

Key Performance Indicator Nine: Number of Cases where an Extension is Authorised

It is important that we respond to their concerns timeously however not all investigations will be able to meet this deadline; however the Whistleblowing Procedure allows an extension where it is necessary to complete the investigation.

The table below details the number of concerns whereby an extension has been authorised against the total number of concerns received at each stage.

Concerns Type	Extension
Stage 1	Not applicatble
Stage 2	Not applicatble
Stage 2 after escalation	Not applicatble

4. Conclusion

NHS Forth Valley's approach to the implementation of the standards is key to ensuring that staff feel safe, supported and have confidence in the fairness of the processes should they feel the need to raise concerns.

Key to the full implementation of the national Whistleblowing Standards was the development of NHS Forth Valley's local guide, which sets out the local procedures for raising a concern under the national Whistleblowing Standards and includes details of the local arrangements, contacts and procedures in place for staff to raise their concerns. This information is available on the intranet, NHS Forth Valley Website and shared widely across the organisation and beyond.

5. Recommendation:

The Forth Valley NHS Board is asked to: -

- **note** that the full implementation of the National Whistleblowing Standards across NHS Forth Valley.
- **note** Whistleblowing activity in NHS Forth Valley in Quarter 3 of 2021/22

Financial Implications

No major impact other than the potential post noted in Workforce Implications, and in addition a small one off cost of £1500.00 and a recurring cost of approximately £500 per annum to support the development within safeguard to data capture the Whistleblowing process.

Workforce Implications

We have agreed an interim model of corporate support for the implementation of the standards and ongoing co-ordination of Whistleblowing processes. A dedicated admin post has been developed and a request for funding for a Band 4 post. This post is currently being supported within the nursing directorate.

In terms of the establishment of a cohort of Speak Up Ambassadors and Advocates interested parties will require to undertake these roles in addition to their substantive posts. However, a local agreement of how senior leaders can enable staff in their teams and departments to fulfil these duties within working hours and will require to be developed and supported over time.

There are no further workforce impacts at this time although supervision and support will be required for Speak Up Ambassadors, Advocates and Confidential Contacts as a key element of our approach.

Risk Assessment

Effective whistleblowing processes can act as both detective and preventative risk management controls to support the organisation and its staff.

Whistleblowing is viewed by NHS Forth Valley as an important source of information that may highlight serious risks to the effectiveness and efficiency of the organisation, with individuals often being best placed to identify deficiencies and problems at the earliest opportunity. If the opportunity to investigate and address these concerns does not result in improvements then there is a potential risk to the quality, safety and experience of patients.

There is also a public confidence and reputation risk, if whistleblowing standards are not fully implemented and visible across the organisation.

Risks to the wellbeing and psychological safety of staff may emerge if NHS FV Senior Leaders are not committed to the process of investigating and learning from any concerns and issues raised by staff.

Relevance to Strategic Priorities

The introduction of the Independent National Whistleblowing Officer Service aims to ensure everyone delivering NHS services in Scotland is able to speak up to raise concerns when they see harm or wrong doing putting patient safety at risk, confident that they can do so in a protected way that will not cause them personal detriment. It also aims to promote a culture of speaking up in the NHS and is a key priority for NHS Forth Valley in 2021/22.

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.

Further to an evaluation it is noted that:

- Screening completed - no discrimination noted

NHS Forth Valley is also carrying out a local Equality Impact Assessment as part of the implementation plan.

Consultation Process

This paper has been developed and considered to date by the following groups. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.



**A guide for staff and those who
deliver health services
in NHS Forth Valley**

Raising Whistleblowing Concerns

Updated process for helping those who deliver services for NHS Forth Valley to raise concerns

From 1 April 2021 there is a new process for raising concerns about patient safety or other issues. The changes mean that there is a new focus on:

- helping staff and those delivering health services raise concerns as early as possible, and
- supporting and protecting staff when they raise concerns.

A three stage process has been developed by the Independent National Whistleblowing Officer (INWO). The process for raising concerns is set out in the National Whistleblowing Standards (the Standards). The first two stages of the process are for NHS Forth Valley to deliver, and the INWO acts as a final, independent review stage. The process aims to give staff support and protection to feel confident in raising concerns if they see something wrong.

Why we want to hear your concerns

Everyone benefits if concerns can be raised early and dealt with promptly and professionally. The new process under the standards is a formal process. But we want to encourage staff to raise concerns before they get to the formal stage, and for managers to listen and learn from staff's concerns.

How to raise a concern

In many cases, concerns can be resolved through informal conversations with colleagues and managers, and through ordinary or 'business as usual' or any other HR policies and processes (such as incident reporting systems or raising an issue in a shift handover meeting).

Where raising a concern informally is not an option - e.g. where confidentiality is an issue or the issue is complex - you can raise a concern in writing, by email, phone or in a face-to-face meeting with a line manager, HR manager, staff-side representatives and Occupational Health Advisers. They will talk to you about the standards if your concern is about whistleblowing, and any other business as usual and HR processes relevant to your concern.

If your concerns have still not been resolved or you wish to raise a concern directly using the whistleblowing standards you can do so by contacting a confidential contact on 07815478106 or by email fv.confidentialcontact@nhs.scot

Who is the confidential contact?

Under the standards, NHS Forth Valley must ensure that all staff have access to a 'confidential contact'. Their role is to provide a safe space to discuss your concerns and to give you the information you need. They also have the knowledge and skills to help you to raise your concern with the appropriate manager.

The confidential contacts across Forth Valley have been identified and are in place to support the whistle blowing standards and also provide wider support, guidance and advice to those providing services on behalf of NHS Forth Valley

The details of the confidential contacts are provided below:

Pauline Donnelly	Email: fv.confidentialcontact@nhs.scot
Catherine MacLean	Tel: 07815478106

Using the Standards

Raising a concern under the standards allows you to access appropriate support. There are a few things that will need to be checked before you can use the process. Your manager or confidential contact will need to check:

- ✓ **Your concern fits the definition of whistleblowing** i.e. is it in the public interest?
- ✓ **If it is being handled through a business as usual process already.** The business as usual process should run its course to avoid duplication.
- ✓ **The outcome you are seeking.** It may be that another process will get you a more appropriate outcome.
- ✓ **If the concern has been raised in time.** It should normally be raised within six months of you becoming aware of the issue of concern.
- ✓ **If you want to use the Standards.** It's your choice. If you choose not to use the Standards the organisation will decide how to investigate.

Please note that you cannot raise an anonymous concern under the Standards, nor can you bring an anonymous complaint to the INWO. However, your identity will be kept confidential under the Standards process.

Confidentiality refers to the requirement not to disclose information about the person raising a concern, unless the law says that it can or must be disclosed. This includes anyone else involved in the process, such as other witnesses.

Anonymity refers to a situation when nobody knows the identity of the member of staff who raised the concerns.

For further information please visit:

[Confidentiality and data protection | INWO \(spso.org.uk\)](https://www.spso.org.uk/Confidentiality-and-data-protection)

[Anonymity and unnamed concerns | INWO \(spso.org.uk\)](https://www.spso.org.uk/Anonymity-and-unnamed-concerns)

Stage 1 (Early Resolution)

Stage 1 of the process involves little action or no investigation. The response will usually be a straightforward solution to the problem. You should get a response within five working days with an explanation of the outcome, and any action that might be taken in response to the issue you raised. You should also get details of how to raise your concern to stage 2 if you are unhappy with the response.

Stage 1 isn't appropriate for serious concerns or concerns that need detailed investigation.

Stage 2 (Investigation)

Stage 2 concerns are usually about serious risks or complex issues that need investigation. You can ask for your concern to be looked at under stage 2 if you think a full investigation is needed.

Whoever is handling your concern will acknowledge it within three days and respond to you in 20 working days. If the investigation is complex and is taking longer, they may need to extend the timescale.

An independent senior manager will investigate your concern. You will get a written response and details of any action in response to your concern. The response should tell you how you can raise your concern to the INWO if you are unhappy with how it has been handled.

Issues your manager or the confidential contact will discuss with you

At the start of the process, your manager or the confidential contact will ask you:

- **What your concern is about.** They will need to know all the details of your concern and what you think needs to be done. You should also raise any urgent issues that need resolved immediately e.g. issues affecting patient safety.
- **Who else is involved.** Other people who know about the issue and also anyone who has investigated already. Knowing this will help to manage and maintain confidentiality.
- **What you want to achieve.** Identifying what you want to achieve will allow your manager or the confidential contact to suggest other appropriate processes. You may need to use more than one process to achieve your aim.
- **Confidentiality.** Confidentiality is key to the Standards. Your details must not be shared with anyone who does not need to know them. Your manager or the confidential contact must discuss with you how your details will be used and stored.

- **What support you might need.** Raising concerns can feel isolating. You should be given support to raise your concern and for any other needs you have including Occupational Health Services.

Writing down your thoughts on these issues before meeting with your manager or the confidential contact will help you with this process.

Bringing your complaint to the Independent National Whistleblowing Officer (INWO) (External Review)

You can contact the INWO at any time for advice if you are not sure about something.

The INWO will normally only investigate a concern after it has been through both stages of the local process. At this point of the process you should have a stage 2 letter which says that you can bring your concern to the INWO. A concern brought to the INWO is referred to as a 'complaint'. You should bring your complaint to the INWO within 12 months of when you first became aware of the issue.

The INWO can consider complaints about:

- Any actions taken by your organisation in response to your concern
- Whether your organisation followed the process laid out in the standards
- How you were treated during and after you raised a concern
- How the organisation supports a culture of speaking up

The INWO will investigate and come to a decision on your complaint. They can :

- Refer the concern back to the organisation if it has not been fully investigated. If you remain dissatisfied with the organisation's further response, the INWO can investigate the complaint.
- Discontinue an investigation where an appropriate resolution has been agreed between the parties.
- Uphold your complaint. The INWO can make recommendations to ensure that the situation doesn't happen again. They can also recommend redress where people have been personally affected.
- Not uphold your complaint.

If you are unhappy with a decision on your complaint, you will have an opportunity to provide comments and express why you feel the decision is not correct.

More information about [independent review by the INWO](https://inwo.spsso.org.uk) is available at inwo.spsso.org.uk

Contact details:

Independent National Whistleblowing Officer
Bridgeside House
99 McDonald Road

FREEPHONE 0800 008 6112
inwo.spsso.org.uk/contact-form

Edinburgh
EH7 4



Whistleblowing Standards : Stage Overview

Anyone raising a concern can go to the INWO and at any point in this process, and the INWO can provide information and advice to support the process

Stage 1 – Early Resolution 5 working days

What to expect at Stage 1

- On the spot explanation and/or action to resolve the matter quickly, in five working days or less
- Extend timescales with agreement if there are exceptional circumstances
- Handled by member of staff receiving concern or referred to appropriate person for early resolution (within five working days) or progressed to stage 2 (within five working days)

Stage 2 – Investigation 20 working days for definitive response

What to expect at Stage 2

- Respond in 20 working days following thorough investigation of concern(s)
- Extend timescales to achieve quality investigations and outcomes
- Response signed off by senior management and must signpost to the INWO, including timescales

INWO consideration

- Concerns that have completed the process will either have been thoroughly investigated or will have been refused by the organisation an initial assessment; these must be signposted to the INWO
- INWO may assess
 - How the concern was handled by the organisation
 - Whether the organisation's decision about the concern was reasonable
 - How the whistleblower was treated through the process
 - How the organisation supports a culture of speaking up

National Whistleblowing Standards

NHS Forth Valley Whistleblowing Procedure

What is Whistleblowing

Whistleblowing may be defined as someone within an organisation raising concerns about a risk of harm or wrongdoing in the public interest. People providing an NHS service may identify risks of harm or wrongdoing, such as malpractice, patient safety issues or regulatory breaches, and wish to speak up about them.

Overview of the procedure for raising concerns

The procedure for raising concerns aims to provide a quick, simple and streamlined process for making sure concerns are dealt with early and locally by capable, well-trained staff. It also includes actions to make sure people who raise a concern receive any support they may need, so that the process allows people to share information safely.

Accessing the standards

If an individual wants to raise a concern there are several possible routes to do so, as outlined in **Appendix 1**.

The Standards (<https://inwo.spsa.org.uk/download>) are applicable across **all NHS services**. This means that they must be accessible to anyone working to deliver an NHS service, whether directly or indirectly. This includes current (and former) employees, bank and agency workers, contractors (including third sector providers), trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social care partnerships.

Raising Concerns: The Two Stage Procedure

The two stage procedure for raising concerns aims to provide quick, simple and streamlined process for making sure concerns are dealt with early and locally by capable, well trained staff. It also includes actions to make sure people who raise a concern receive any support they may need, so that the process allows people to share information safely.

What happens in each stage of the procedure:

Stage 1 – Early Resolution

Stage 1 of the process involves little or no investigation and a response will usually be a straight forward solution to the problem. It is defined as a matter that can usually be closed using local resolution within a period of 5 working days.

Stage 2 – Investigation

These concerns are usually about serious risks or complex issues that need investigation.

Independent External Review

If the Whistleblower is not satisfied with the response they have received to Stage 2, they can take their concern to the INWO for Independent External Review.

Concerns that have completed the process will either have been thoroughly investigated or will have been refused by the organisation at initial assessment; these must be signposted to the INWO

- INWO may assess
 - How the concern was handled by the organisation
 - Whether the organisation's decision about the concern was reasonable
 - How the whistleblower was treated through the process
 - How the organisation supports a culture of speaking up
 -

Routes to raising concerns

If an individual wants to raise a concern there are a number of ways in which they can do so, as outlined in the flowchart at **Appendix 2**.

In many cases, concerns can be resolved through informal conversations with colleagues and managers, and through ordinary or '**business as usual**' processes. Where raising a concern informally is not an option - e.g. where confidentiality is an issue or the issue is complex – individuals can raise a concern in writing, by phone or in a face-to-face meeting with a line manager, HR manager, staff-side representatives and Occupational Health Advisers.

When an individual raises a concern

There are a number of important factors for a manager to consider when an individual raises a concern including whether the concern can be addressed through business as usual or should be progressed through the Whistleblowing procedure.

It is important for managers to:

- Listen carefully to the individual raising the concern
- Respond positively and clearly and provide advice on the type of support available
- Assess the seriousness and risk then seek advice or escalate as appropriate
- Maintain good communication with the individual raising the concern
- Act fairly and never judge anyone for raising a concern
- Seek advice and or support if required

If the manager and individual agree that the matter can be resolved locally, or through another route or procedure which does not involve Whistleblowing then the matter should be dealt with under '**business as usual**'. If the concern is not resolved through business as usual, the WB process can be revisited

Concerns to be progressed through the Whistleblowing Procedure

If an individual specifically wants to raise their concern under the Whistleblowing process then they should be advised of the '**two stage procedure**'. The manager should assess whether the matter can be resolved locally (Stage 1) with early resolution and the manager should take forward the matter appropriately. If the

matter cannot be resolved at Stage 1 then the process should move to Stage 2 – Investigation. These concerns will include:

- Issues relating to serious, high risk or high profile issues
- Complex issues that require a detailed investigation
- Issues where the individual believes a full investigation is required

If a concern relates to high risk, or high profile issues then the manager receiving the concern may wish to consider escalating the matter to a senior manager in the organisation to investigate further.

If the individual does not feel like their issues have been addressed appropriately in Stage 1 of the process then they can ask for it to be investigated through the Stage 2 immediately after receiving the outcome at Stage 1 or some time later.

Raising a concern at Stage 1 (Early Resolution)

There are a number of ways in which an individual can raise a concern, these include:

Directly to Line Manager	
Confidential Contacts Pauline Donnelly Catherine Maclean	fv.confidentialcontact@nhs.scot 07815478106
Safeguard (Freedom to Speak)	Intranet
Staff Side Representative	

If the individual raises a concern directly to their manager then this should be recorded in Safeguard under the ‘Freedom to Speak’ section of the system as outlined at **Appendix 3**. The Guardian of safeguard will then be notified of the concern. It is the manager’s responsibility to review the concern and respond back to the individual within 5 working days. The response should be in writing unless it has been agreed with the individual that this is not required.

If there is a reason why the response to the concern cannot be provided within 5 working days then the manager should advise the individual as to the reason and why the timescale cannot be met, and when the individual can expect to receive a response. This should be no longer than 10 working days from receipt of the concern.

The individual may want to raise their concern directly to the confidential contacts by phone or email as detailed above. If the concern is not appropriate for business as usual or the individual wants to raise their concerns under the whistleblowing procedure, the Whistleblowing Officer has a duty to follow NHS Forth Valley’s Stage 1 Standard Operating Procedure as outlined in **Appendix 4**.

Raising a concern at Stage 2 (Investigation)

If the individual is not satisfied with the response at Stage 1 of the Whistleblowing procedure, or if the agreed action has not been taken then they can take their concern to Stage 2: Investigation.

If an individual wishes to escalate a concern from Stage 1 to Stage 2 then the individual, manager or confidential contact should contact the Whistleblowing Officer (01324 566415) or (fv.whistleblowing@nhs.scot) who will in turn make the necessary changes to safeguard to allow the concerns to be recorded under Stage 2: Investigation of the process – refer to **Appendix 5**. The Whistleblowing Officer will progress the concern in line with the policy, including identifying an investigator to take forward the investigation of concerns.

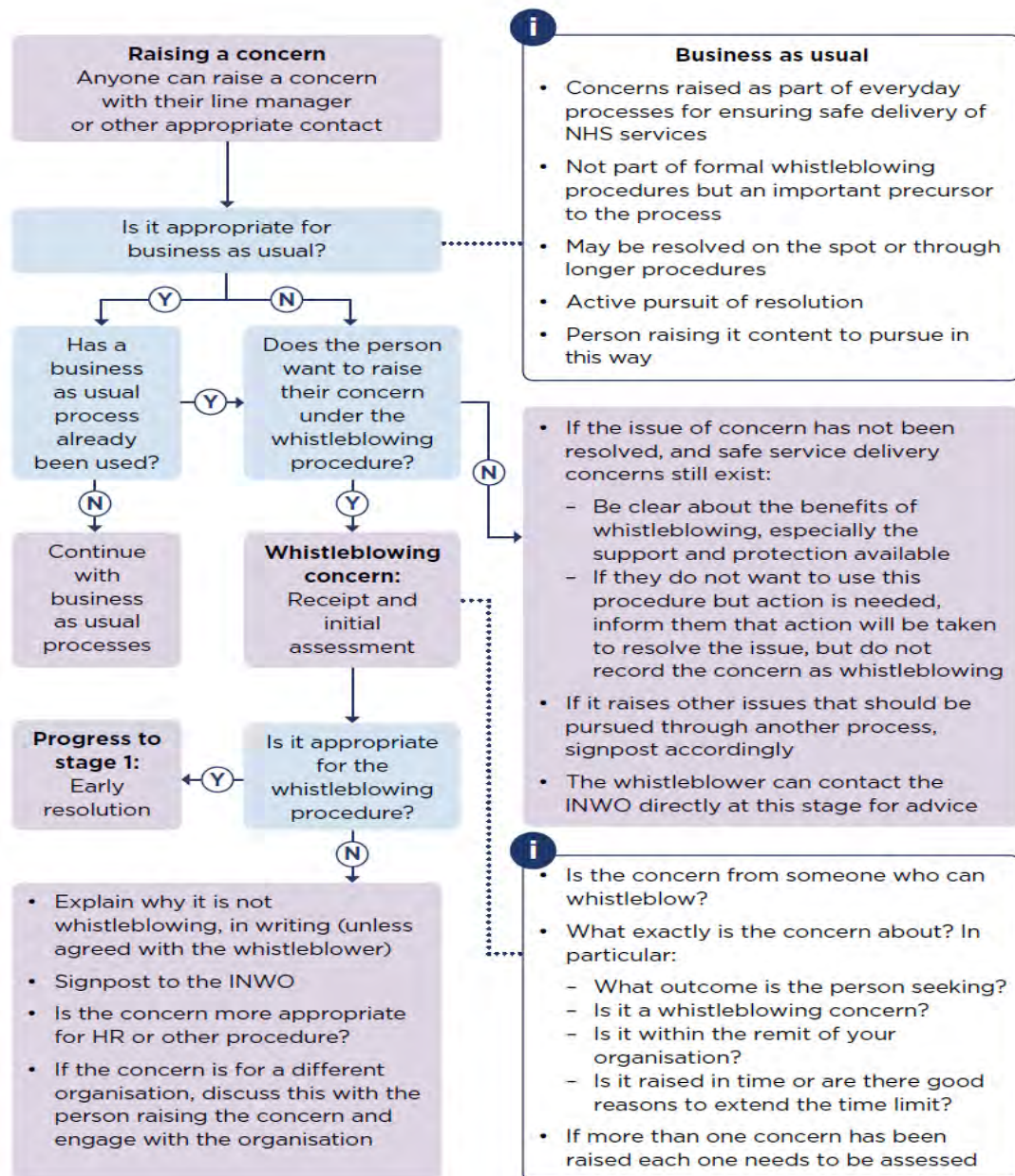
Raising a Concern involving an Executive Director / Chief Officer or Board Member

If a member of staff wishes to raise a whistleblowing concern at either Stage 1 or 2 which involves Executive Directors/Chief Officers then this should be raised to the Chief Executive or the Chair. If the whistleblowing concern involves the Chief Executive or a Non Executive Director then this should be raised with the Chair of the Board. If the concern involves the Chair of the Board this will require to be raised with the Scottish Government and Non-Executive Whistleblowing Champions would be able to assist with the process.

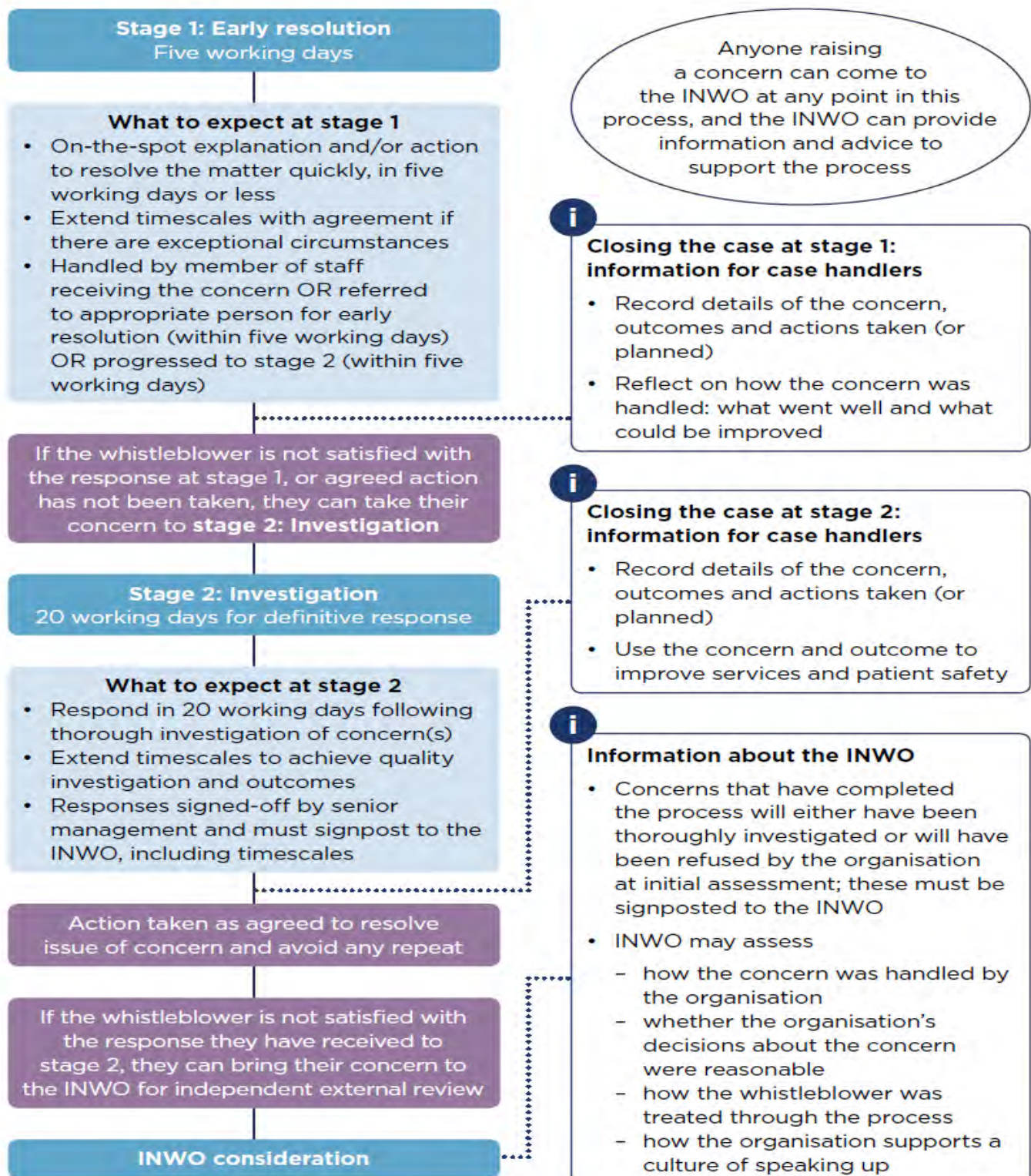
For further information and advice

<https://inwo.spsso.org.uk/national-whistleblowing-standards>

Appendix 1



Appendix 2



Appendix 3

The Freedom to Speak Up report published in 2015 set out the findings of the independent review undertaken by Sir Robert Francis QC. In response to the recommendations and to support NHS employees we have created a formal incident report form to raise concerns and help standardise the way we can support staff who raise concerns.

Details of Person Completing Freedom to Speak Up form

Anonymous

☐

Surname

First Name

Job Title

Work Email Address

Department Search

Clear Location

People Involved In This Event

Person Details 1

☐ Service User

☒ Staff

☐ Member of Public

☐ Organisation Reputation

Clear Details

Staff Name (Surname/First Name)

Surname Firstname

Surname

Forename

Was another Staff Member Involved?

☐ Yes ☐ No

What Happened and When

Date of concern

Description of Concern

Cause Search

Clear Details

Primary Category

FTSU (Freedom To Speak Up)

Primary Sub-Category

Where the Event Happened/Found

Where in the Organisation did this occur?

Department Search

Which Site does the concern relate to?

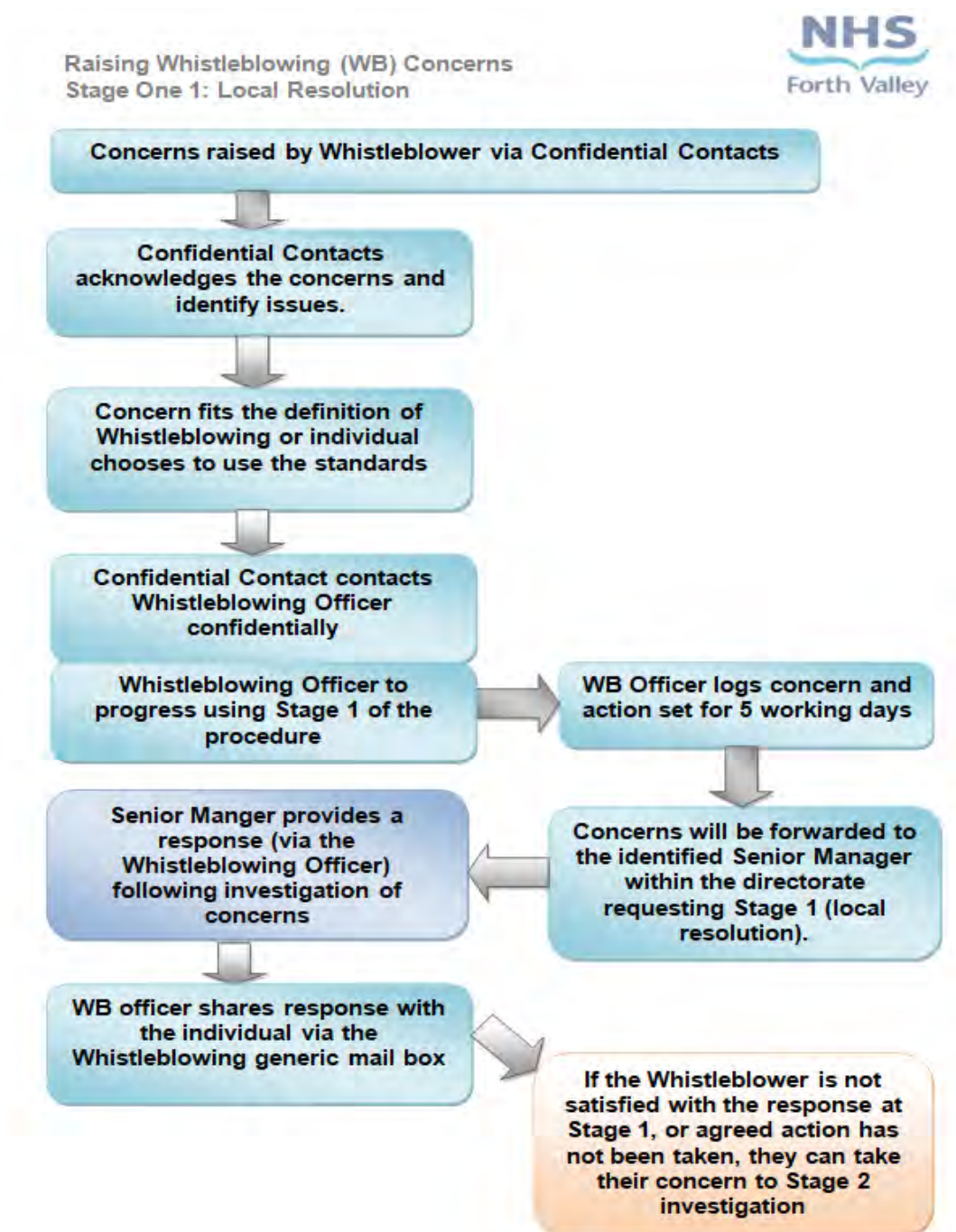
Which department/area does the concern relate to?

Location Details

Clear Details

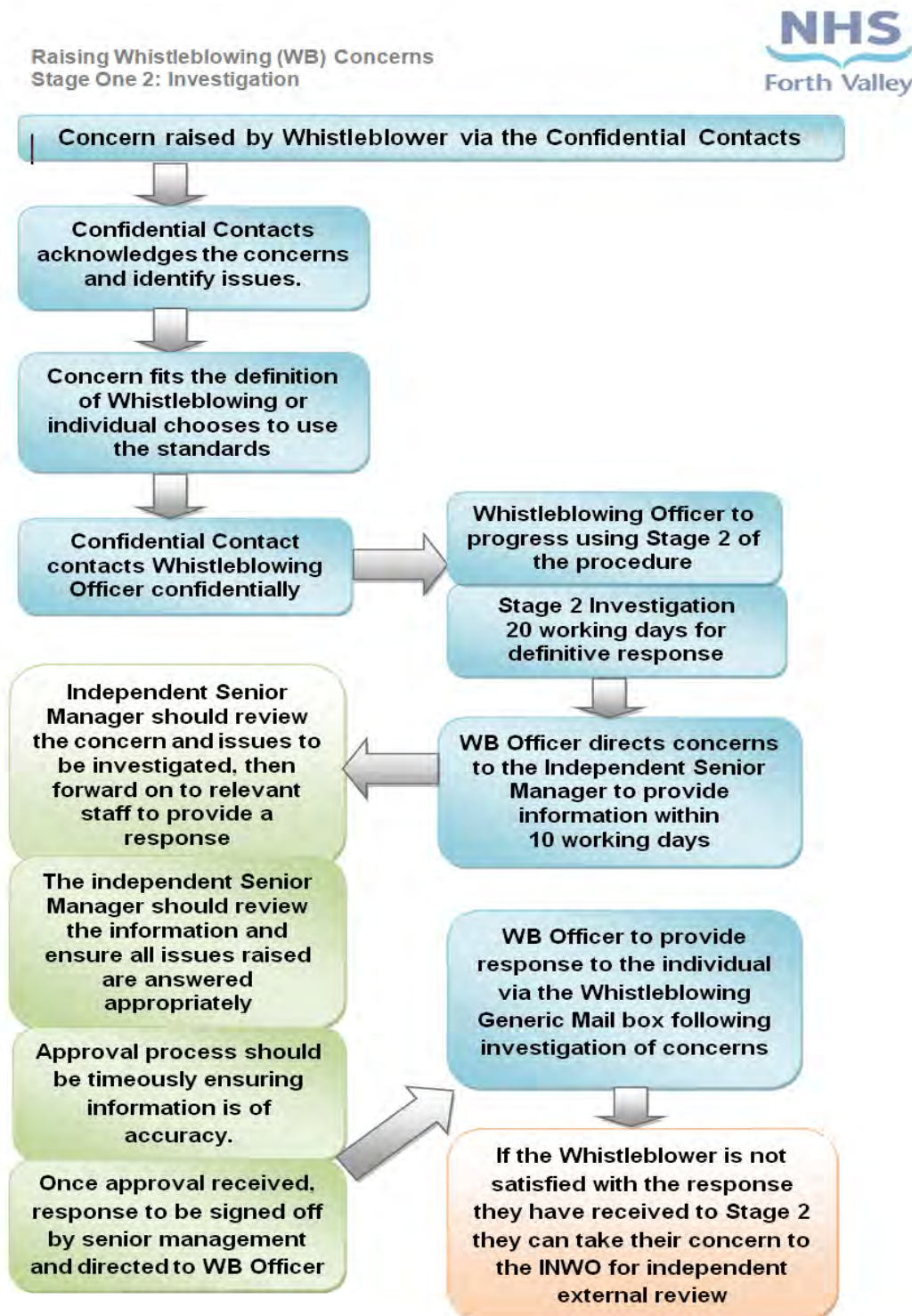
Appendix 4

Stage 1 (Early Resolution)



Appendix 5

Stage 2 (Investigation)



Appendix 2

Key Performance Indicators

A statement outlining learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns;
A statement to report the experiences of all those involved in the Whistleblowing procedure (where this can be provided without compromising confidentiality)
A statement to report on levels of staff perceptions, awareness and training;
The total number of concerns received
Concerns closed at stage 1 and stage 2 of the Whistleblowing procedure as a percentage of all concerns closed
Concerns upheld, partially upheld and not upheld at each stage of the Whistleblowing procedure as a percentage of all concerns closed in full at each stage
The average time in working days for a full response to concerns at each stage of the Whistleblowing procedure
The number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working days
The number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working days
The number of concerns at stage 1 where an extension was authorised as a percentage of all concerns at stage 1
the number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at stage 2.

NHS FORTH VALLEY BOARD

TUESDAY 29 MARCH 2022

**8.1 Finance Report
Seek Assurance**

Executive Sponsor: Mrs Cathie Cowan Chief Executive

Author: Mr Scott Urquhart, Director of Finance

Executive Summary

This report provides a summary of the NHS Forth Valley financial position for 2021/22.

Recommendation

The NHS Board is asked to:

- **note** a projected break-even financial position against revenue and capital resource limits for 2021/22 year-end, subject to key risks highlighted in the report

Key Issues to be considered

Issues are highlighted within the attached Finance Report.

Financial Implications

Any relevant financial implication will be discussed within the Finance Report.

Workforce Implications

Any workforce implications are highlighted within the Finance Report.

Risk Assessment

Key risks are highlighted within the appropriate level of Risk Register.

Relevance to Strategic Priorities

There is a statutory requirement for NHS Boards to ensure expenditure is within the Revenue Resource Limit (RRL) and Capital Resource Limit (CRL) set by Scottish Government.

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process. Further to an evaluation it is noted that the paper is not relevant to Equality and Diversity.

Consultation Process

Directorate Management Teams with Finance colleagues.

1.0 EXECUTIVE SUMMARY

- 1.1 NHS Boards are required to perform within the annual funding limits set by Scottish Government. The financial measures which NHS Forth Valley must operate within are:
- Revenue Resource Limit (RRL)
 - Capital Resource Limit (CRL)
 - Cash Requirement

1.2 **2021/22 Financial Position**

The Revenue outturn projection for 2021/2022 is a break-even position against annual budget of £785.3m, subject to receipt of final anticipated budget allocations. The in-year financial position to 28th February 2022 is a small underspend of £0.015m (ref Appendix 1): A timetable for production of year-end accounts and external audit review has been finalised in line with Scottish Government reporting timescales.

Workforce costs continue to demonstrate an increasing monthly expenditure trend (Appendix 2) as a result of multiple issues including pay awards, arrears payments, additional staff employed to deliver approved investments, and temporary staff costs to meet absence, annual leave and vacancy cover. This will be a key area of focus going forward.

A process for establishing and quantifying the level of financial commitment for annual leave buy back and carry forward as at 31st March 2022 for staff who have been unable to take their full annual leave allowance has been put in place and this will be accounted for in line with previous years.

A Scottish Government letter dated 9th February 2022 set out details of further Covid-19 funding. The available balance of funding at year end, which is expected to total £27.5m subject to final review, will be carried forward into 2022/23 as an earmarked Covid recovery reserve within Integration Joint Boards. Further guidance is expected on how the funding will require to be deployed in 2022/23 against key priorities in supporting Covid-19 recovery,

The pandemic has impacted on the delivery and timing of recurring cost savings schemes and value improvement plans. The 2021/22 savings requirement of £32.4m is anticipated to be achieved in the current year with year-end medicines rebate schemes expected to bring the plan to completion. A significant proportion (approx. 50%) of savings have been met on a non-recurring basis from one-off sources

The capital outturn projection for 2021/22 remains consistent with previous reports at break-even (ref Appendix 3), Capital expenditure to end of January 2022 totals £11.048m. The National Treatment Centre infrastructure development accounts for the majority of the £10.690m balance expected to be fully committed by end of March 2022.

The NHS Board Financial Plan for 2022/23 and future years (revenue and capital) is presented to the Board under separate cover.

2.0 CLINICAL DIRECTORATES

Clinical Directorates reported an overspend of £1.346m to 28th February 2022.

Directorate	Annual Budget £m	YTD Budget £m	YTD Spend £m	YTD Variance £m
Acute Services	191.493	173.592	174.676	(1.084)
Cross Boundary Flow	58.228	53.368	53.681	(0.313)
Community Services incl Prisons	14.401	13.136	12.742	0.394
Women & Children	53.923	49.551	48.963	0.588
Specialist Mental Health	15.179	13.861	15.062	(1.201)
Ringfenced and Contingency Budgets	51.933	(0.820)	0.000	(0.820)
Income	(30.268)	(28.035)	(29.125)	1.090
Total	354.889	274.653	275.999	(1.346)

Note these budgets include services defined as 'Set Aside'

- 2.1 Costs directly attributable to COVID-19 have been identified and matched with budget, on a non-recurring basis and work continues to develop on projected covid impact into the new financial year across key themes.
- 2.2 Acute Services report an overspend to February of £1.084m. The position has improved due to the receipt of an additional oncology drugs rebate and a theatres underspend, and confirmation of National Treatment Centre funding in month. There continue to be capacity pressures at both the front door and downstream wards giving rise to the requirement to appoint supplementary staffing through bank, agency and overtime.
- 2.3 Cross Boundary Flow has a £0.313m overspend to February. In Mental Health Forensic services, high levels of activity continue to be experienced. The most recent information indicates an average of 6 patients per month at a full year cost of £1.7m. In addition a further 3 additional patients are receiving therapy for Cystic Fibrosis in-month, bringing the total to 32. These costs have been offset by benefits from the Service Level Agreement with NHS Greater Glasgow & Clyde.
- 2.4 For Community Services including Prisons, an underspend to February of £0.394m is reported. This is principally due to historical underspends in childhood immunisation prescribing, and Health Improvement services.
- 2.5 The Women and Children's Directorate continues to report an underspend to February in line with the forecast. This is driven by lower than anticipated prescribing costs particularly on HIV drugs.
- 2.6 In Specialist Mental Health services, there continues to be significant staffing pressure experienced in in patient wards both at Bellsdyke and Forth Valley Royal Hospitals. These pressures are being managed by the deployment of Nursebank and agency staff.

3.0 CORPORATE FUNCTIONS AND FACILITIES

Corporate functions and Facilities report an underspend of £0.158m to 28th February 2022.

Service	Annual Budget £m	YTD Budget £m	YTD Spend £m	YTD Variance £m
Facilities & Infrastructure	100.686	92.112	91.963	0.149
<u>Corporate Services</u>				
Director of Finance	3.634	3.331	3.251	0.080
Area Wide Services	(0.154)	(0.948)	(0.791)	(0.157)
Medical Director	8.795	7.841	7.724	0.117
Director of Public Health	3.185	2.780	2.781	(0.001)
Director of HR	4.776	4.119	4.015	0.104
Director of Nursing	3.443	3.135	3.287	(0.152)
Chief Executive	2.022	1.834	1.814	0.020
Portfolio Management Office	0.545	0.500	0.349	0.151
COVID-19	17.226	17.226	17.226	0.000
Immunisation / Other	1.590	1.458	1.611	(0.153)
Total	145.748	133.388	133.230	0.158

- 3.1 The Facilities & Infrastructure Directorate are reporting an underspend position in line with updated outturn forecast, with offsetting over and underspends across a range of budget headings.
- 3.2 Corporate Services cover a range of services of functions including Finance, Human Resources and Public Health. The net variance position across corporate services is broadly break even,

4.0 HEALTH AND SOCIAL CARE PARTNERSHIPS

- 4.1 Health services in scope for Health and Social Care Partnerships report an underspend of £1.203m to 28th February 2022. Forecast outturns and risk share arrangements have been factored into the overall NHS Board outturn projection.

HSCP	Annual Budget £m	YTD Budget £m	YTD Spend £m	YTD Variance £m
<u>Falkirk</u>				
Operational Services	64.238	58.388	56.515	1.873
Universal Services	80.106	73.519	74.780	(1.261)
Subtotal	144.344	131.907	131.295	0.612
<u>Clackmannanshire and Stirling</u>				
Operational Services	53.051	47.471	46.188	1.283
Universal Services	81.878	75.011	75.703	(0.692)
Subtotal	134.929	122.482	121.891	0.591
TOTAL	279.273	254.389	253.186	1.203

- 4.2 Health and Social Care Partnership budgets detailed above are Health budgets designated as in scope for HSCP integration, excluding services defined as Set Aside. Financial pressures related to 'Set Aside' services are met by NHS Forth Valley. These services are currently captured within the Clinical Services areas of this report.
- 4.3 Any unspent balance of Covid-19 funding at year end will be factored into IJB reserves to be carried forward into the new financial year. Further guidance is expected to be received in the deployment of that resource in 2022/23.

5.0 RISK

- 5.1 Financial Risks are assessed on a quarterly basis. Work has been completed supported by the Corporate Risk Manager to review current financial risks on a "deep-dive" basis, with outcomes presented to Performance and Resources Committee in October 2021. This demonstrates how assurance can be gained by undertaking a risk criticality assessment and then identifying lines of defence, from operational management ownership through to independent assurance from Internal and External Audit. The current operational risk profile is set out in Appendix 4.
- 5.5 A full schedule of risks aligned to the financial plan is outlined as part of the financial planning document which is presented under separate cover.

6.0 CAPITAL

- 6.1 Forecast Capital Expenditure for 2021/22 is £21.738m, comprising Scottish Government General Allocation of £6.085m, and ring-fenced funding to the value of £15.653m. A summary of the Capital position and forecast is provided in Appendix 3 of this report. Movements on capital resources between January and February are summarised below.

	£'m
Capital Resource Limit as at 31st January 2022	21.093
Return of Banked Funding	0.218
GP Sustainability Loans	-0.293
ASDU Washers	0.250
Electric Vehicle Charging points	0.120
Equipment Replacement	0.350
Capital Resource Limit as at 28th February 2022	21.738

- 6.2 Total capital spend to end of February 2022 is £11.048mm, with a further £10.690m to be to be further committed by end of March. £18.5m of this relates to the Treatment Centre building.

	£m
<u>Capital Resources</u>	
General Allocation	21.738
Property Disposals	0.000
Total Capital Resources	21.738
<u>Capital Expenditure</u>	
Expenditure to 28 th February 2022	11.048
Anticipated expenditure March 2022	10.690
Total Projected Expenditure	21.738

- 6.3 Total annual expenditure by category / budget area for the period 1st April to 28th February 2022 is as follows:

Elective Care – pre-construction work continues with the Elective Care project. Work is anticipated to commence in March 2022 with facility being operational in October 2022. The full expenditure commitment will be reflected in the March position

Information Management & Technology – projects are nearing completion within IM&T department as approved by the Digital & eHealth Project Board and as at 28th February 2022 the sum of £2.490m has been spent from an available budget of £2.622m.

Medical Equipment – expenditure to date on Medical Devices equates to £4.031m including an in-month increase to the value of £1.214m.

Facilities & Infrastructure – expenditure to date within Facilities and Infrastructure equates to £3.848m, predominantly on Urgent Care redesign, Statutory Standards and Primary Care premises.

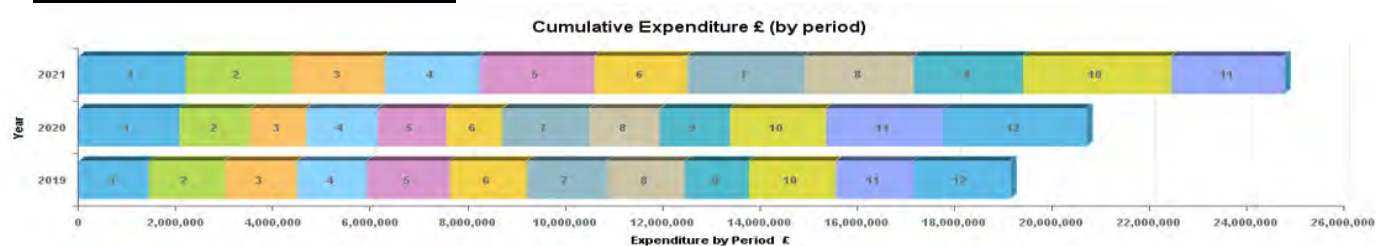
NHS Board – as at 28th February 2022 the sum of £0.050m has been spent from the Dental Infrastructure fund on works to Carronshore Dental practice. In addition, the full £0.600m allocation on Covid-19 related projects has been spent.

Appendix 1: Revenue Financial Position as at 28th February 2022

Budget Area	Annual Budget £m	YTD Budget £m	YTD Spend £m	YTD Variance £m
NHS Services (incl Set Aside)				
<u>Clinical Services</u>				
Acute Services	191.493	173.592	174.676	(1.084)
Cross Boundary Flow	58.228	53.368	53.681	(0.313)
Community Services incl Prisons	14.401	13.136	12.742	0.394
Women and Children	53.923	49.551	48.963	0.588
Specialist Mental Health	15.179	13.861	15.062	(1.201)
Income	(30.268)	(28.035)	(29.125)	1.090
<u>Non- Clinical Services</u>				
Facilities and Infrastructure	100.686	92.112	91.963	0.149
Corporate Services	45.062	41.276	41.267	0.009
<u>Other</u>				
Ringfenced and Contingency Budgets	51.933	(0.820)	0.000	(0.820)
Partnership Funds - Falkirk	3.175	0.000	0.000	0.000
Partnership Funds - Clacks Stirling	2.257	0.000	0.000	0.000
Subtotal	506.069	408.041	409.229	(1.188)
Health & Social Care Partnerships				
Falkirk HSCP	144.344	131.907	131.295	0.612
Clacks/Stirling HSCP	134.929	122.482	121.891	0.591
Subtotal	279.273	254.389	253.186	1.203
Total	785.342	662.430	662.415	0.015

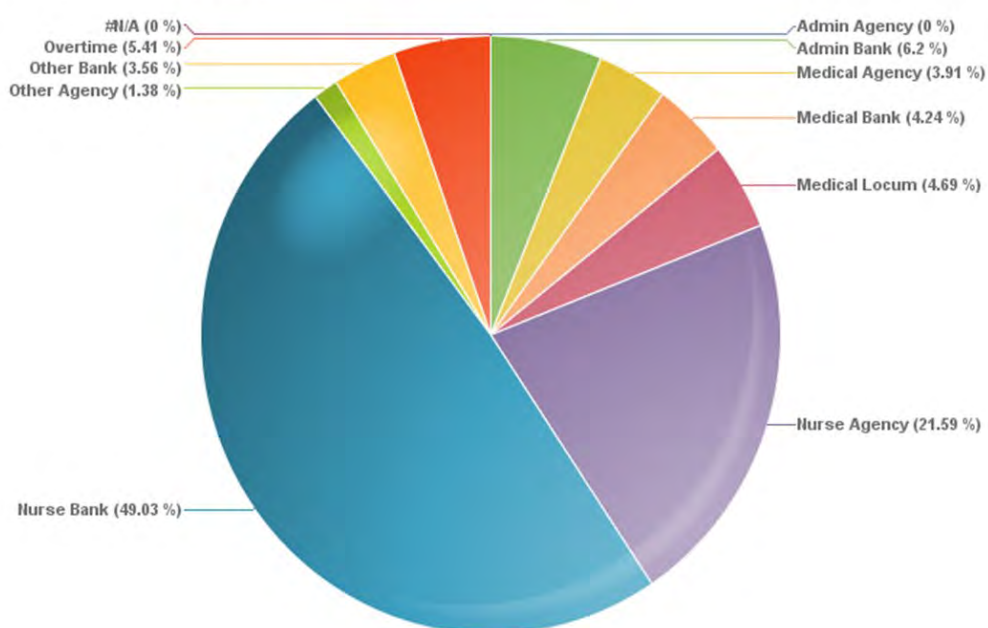
Appendix 2 – Workforce Cost Profile

Temporary Staff Costs by Month



Temporary Staff Costs by Source

Analysis of Current Year Non Core Costs



Total Pay Costs - Trend Analysis



Appendix 3: Capital Financial Position – 28 February 2022

Capital Resource Limit for the period to 28th February 2022	Annual Budget £000	Spend to 28 Feb 2022 £000	Forecast Position 31 Mar 2022 £000
Resources			
General Allocation	6,085		6,085
Other Allocations	17,503		17,503
Indirect Capital Charged to Revenue	(1,850)		(1,850)
Total Gross Direct Capital Resource	21,738		21,738
Expenditure			
Elective Care	10,488	29	10,488
Information Management & Technology	2,622	2,490	2,622
Medical Equipment	4,612	4,031	4,612
Facilities & Infrastructure	4,994	3,848	4,994
NHS Board	(978)	650	(978)
Total Gross Direct Capital Expenditure	21,738	11,048	21,738
Saving/ (Excess) Against CRL	0	0	0

Appendix 4 – Assessment of Financial Risks

Risk	Rating (R/A/G)
There is a risk that costs related to Covid-19 will impact on the Boards ability to meet its financial targets and that Covid-19 additional costs are not fully funded in future years.	Amber
There is a risk on future years financial sustainability based on increasing underlying recurring costs and uncertainties on funding arrangements beyond 2021/22.	Amber
There is a risk that economic outlook and impact of demographic change continues to drive requirement for recurrent cash savings which is unsustainable without significant service change.	Amber
There is a risk that the Board's cost improvement programme will not fully deliver, and that timing of some plans will slip.	Amber
There are uncertainties associated with EU withdrawal arrangements which carry potential financial risk.	Amber (reducing)
There is a risk that capacity issues resulting from discharge and activity profiles, and workforce pressures lead to increased staffing and service costs above forecast.	Red
There is a risk that additional financial contributions required from partner organisations to meet IJB financial pressures will exceed planned levels, in relation to both health and social care services.	Amber
There is a risk that service level agreements will significantly vary from the anticipated income and expenditure position.	Amber
There is a risk that areas of specific clinical service sustainability risk will require additional financial resources to maintain safe and effective services for patients.	Amber
New Drugs – the proportion of spend on hospital drugs has been rising above inflation year on year. Approvals for new high cost drugs have significant impact on spend profile.	Amber

Appendix 5 - Savings Position

	To Date	Anticipated Year End Savings		
	Total Achieved February 2022 £000	Recurring £000	Non Recurring £000	Total £000
Planned Savings Schemes				
<u>Medicines Efficiencies</u>				
Prescribing Improvement Initiative	579	742	0	742
Prescribing Efficiencies / Rebates	1,666	0	2,624	2,624
<u>Acute Workstream Savings Delivery</u>				
Workforce Redesign	554	126	858	984
Value Management	0	0	100	100
Income generation	188	0	388	388
Discretionary spend	216	0	216	216
Service Redesign				TBC
Local contracts review				TBC
<u>Innovation and Digital Development</u>				
Travel Costs	512	600	0	600
Texts Savings	0	45	0	45
Calls Savings	0	65	0	65
Printing/ Photocopying etc	65	200	0	200
Travel Time				<i>efficiency</i>
<u>Financial Grip and control</u>				
Rephasing of land sale revenue	5,211	0	5,211	5,211
Balance sheet opportunities	2,483	0	2,635	2,635
Insurance & Contract Rebate	798	0	1,011	1,011
<u>Unplanned Financial Benefits</u>				
Reduction in planned and unplanned activity	181	0	481	481
Other	1,738	0	1,738	1,740
<u>Financial Plan Slippage</u>				
Slippage in brought forward central budgets	14,364	14,287	110	14,397
Planned investments delayed or postponed	961	0	961	961
Total	29,516	16,065	16,333	32,400

FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

9.1 Communications Update Report For Assurance

Executive Sponsor: Mrs Cathie Cowan, Chief Executive

Author: Mrs Elsbeth Campbell, Head of Communications

Executive Summary

This paper provides an update on the communications work undertaken during November 2021 - March 2022. It also provides examples of some of key service developments, media issues and digital developments during this period.

Recommendation

The Forth Valley NHS Board is asked to: -

- **note** the update and ongoing activity to support the response to the ongoing Covid-19 pandemic, service remobilisation and ongoing development of internal and external communications.

Key Issues to be Considered

The ongoing Covid-19 pandemic continues to attract considerable media attention, particularly in relation to the impact on local health and care services over the winter period and the work underway to tackle the backlog and reduce waiting times. Like most NHS Boards across Scotland, NHS Forth Valley continues to face unprecedented capacity and staffing pressures due to large numbers of seriously ill people with complex needs, both in the community and local hospitals. Communications plays a vital role in providing information, advice and reassurance to local patients, families and members of the public. Despite the ongoing pandemic, work continues to promote a wide range of service developments, improvements and achievements across the organisation.

Financial Implications

There has been no additional financial costs and efforts continue to build on existing internal and external communication channels and work with partner organisations to share information and advice as widely as possible.

Workforce Implications

The Communications Team, like many departments, has faced challenges associated with staff working remotely and shielding requirements however the Team has worked hard to overcome these and ensure that services have been maintained throughout the pandemic.

Risk Assessment

Accurate, timely and relevant communications, tailored to the needs of specific audiences can help pressure on local services, reassure the public and ensure staff are well informed.

Relevance to Strategic Priorities

Internal and external communications have played a vital role throughout the pandemic and continue to support organisation's wider strategic and operational response.

Equality Declaration

The author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that:

- Screening completed - no discrimination noted

Communications Update Report

November 2021 - March 2022

OVERVIEW

Like NHS Boards across Scotland, NHS Forth Valley continues to face capacity and staffing pressures. These pressures were particularly challenging at the beginning of the year, and as a result, a decision was taken postpone a number of non-urgent operations for a 6-week period. This temporary measure helped protect vital emergency, cancer care and other critical health services by freeing up staff to support essential health services and provide cover for areas experiencing significant staff shortages due to Covid-19. It also helped free up capacity to deal with a sharp increase in the numbers of patients who required to be admitted to hospital due to Covid-19 and other serious illnesses or injuries. Normal theatre activity resumed on 21st February 2022 and the majority of operations which were postponed will be carried out by the end of March 2022.

Work continued with NHS Forth Valley's vaccination team to promote our local Covid-19 vaccination programme and encourage high uptake levels across all eligible groups. This included widespread use of social media to promote drop-in clinics for anyone aged 12 and, highlight mobile vaccination sessions and raise awareness of a number of local pharmacies which are now able to offer Covid-19 vaccinations. Work was also undertaken with local council communication colleagues to promote local Covid-19 testing venues, collection points and availability of home testing kits.

Despite ongoing service pressures, efforts were made to promote a number of new initiatives and achievements. These included work to showcase the work of a wide range of healthcare professionals based within GP Practices during a visit by the Health Secretary to Dunblane Medical Practice, celebrate the success of Forth Valley Royal Nurse Vicky Wright who was part of the GB Women's Curling Team which won a gold medal at the Beijing Winter Olympics and the new Guinness World Record set by local patient Anne Bell - the longest surviving recipient of an artificial heart valve.

ACTIVITY SNAPSHOT

29,389

FACEBOOK

Followers on Facebook

27

MEDIA RELEASES

The number of proactive releases issued

16,900

TWITTER

Followers on Twitter

162

MEDIA ENQUIRES

The number of media enquiries received, managed and responded to.

50,800

HIGHEST REACH

Highest performing post on Facebook

116,900

AVERAGE MONTHLY REACH

The number of people who have had content/posts from our Facebook page visible on their screen/newsfeed

18,489

AVERAGE DAILY REACH

The number of people who have had content/posts from our Facebook page visible on their screen/newsfeed

4,871

INSTAGRAM

Followers on Instagram

KEY HIGHLIGHTS

Vicky Receives a Hero's Welcome

Olympic gold medallist curler Vicky Wright received a hero's welcome when she returned to Ward B11 for her first shift after her recent stunning success in the Beijing Winter Olympics.

She was greeted with cheers and clapping by colleagues and the ward was decorated with flowers, posters, bunting and balloons.

There was even a makeshift curling rink which Vicky just had to try out, easily scoring a bullseye!



Staff also made a special gold medal celebration cake and erected a blue plaque outside the entrance to the surgical ward to mark her incredible achievement. The Communications Department worked closely with Vicky and her colleagues to highlight her progress before, during and after the Olympics, including a media briefing to coincide with her first day back at work. These attracted widespread international, national and local media coverage.



KEY HIGHLIGHTS

Pharmacy Unsung Heroes

Work was undertaken to promote the work of our pharmacy teams and highlight the important role they play in supporting the delivery of the local Covid-19 vaccination programme and ensuring patients have access to the latest medication and treatments.

NHS Forth Valley's pharmacy vaccine team have delivered more than 350,000 vaccines since they moved to a new centre within Falkirk Community Hospital in November 2021. The new vaccine centre provides vital space, including a cold room facility which can store more than triple the number of vaccines previously held at Forth Valley Royal Hospital.

The purchasing, storage and distribution team at Forth Valley Royal Hospital have also been praised for ensuring that the availability and supply of Covid-19 medicines throughout the pandemic, reacting to changes in demand, often at very short notice. This includes the recent introduction of new antibody and antiviral treatments for those at highest risk.



New Diagnostic Device for Bowel Conditions

Forth Valley patients with certain bowel symptoms are benefiting from a new diagnostic technique which could improve diagnosis as well as avoid the need for a colonoscopy and help reduce waiting lists.

The new digital probe, known as the LumenEye® X1 has been introduced at the Endoscopy Unit at Forth Valley Royal Hospital, the first hospital in Scotland to offer it.

The new service enables our colorectal surgeons and nurse endoscopists to examine patients referred with a number of symptoms, including rectal bleeding, and carry out follow up checks in patients who have undergone bowel surgery. It can help quickly identify a number of common conditions including polyps, inflammation and haemorrhoids so that many patients do not need to undergo further investigations, such as a colonoscopy, helping to free up diagnostic capacity for those with more serious conditions such as cancer and other bowel diseases.



KEY HIGHLIGHTS

National Recognition for Local GP Practice Teams

Health Secretary, Humza Yousaf, visited Dunblane Health Centre on 7th February to meet the multidisciplinary team of healthcare professionals who have been supporting local patients for some time. This included the advanced nurse practitioner, advanced practice physiotherapist, pharmacist, primary care mental health nurse and healthcare support worker based at the GP Practice.



Cardiology Patient Sets New Guinness World Record

Work was undertaken with the Cardiology Department to highlight a new Guinness World Record set by a local patient who underwent pioneering heart surgery almost 50 years ago. Seventy-seven-year-old Anne Bell, from Banknock in Falkirk, is the longest surviving recipient of a single artificial heart valve replacement. The operation to replace her mitral heart valve was carried out on 4th December 1972 at the former Meanskirk Hospital in Glasgow when Anne was just 28 years old.



Following her operation, Anne's care transferred to the former Falkirk and District Royal Infirmary and then Forth Valley Royal Hospital where she undergoes regular checks in the Cardiology Department.

ICU Patients Get a Helping Hand From RITA

Thanks to funding from the Organ Donation Committee, a new piece of equipment is now available in the Intensive Care Unit at Forth Valley Royal Hospital which allows patients to use apps, games and participate in other leisure activities as part of their recovery.

The software, known as RITA (Reminiscence Interactive Therapy Activities) has been used in the past to support the care of patients with dementia. But it is also recognised to be useful in looking after people with delirium and other



health conditions so is well suited to the critical care environment. The system provides a range of interactive devices for patients and staff to access resources to engage and focus patients, whilst drawing on familiar and comforting sensory experiences.

The Communications Team received, managed and responded to a large number of media enquiries during the period. Many of these related to waiting times, (particularly in relation to the 4hr access standard and CAMHS) and the ongoing impact of Covid-19 across hospital, community and primary care services.

Work was undertaken to promote a wide range of service developments and ensure local media were kept updated on the ongoing roll out of the Covid-19 vaccination programme and the latest public health advice.

More than 20,000 on hospital waiting lists in Forth Valley as region faces Covid backlog

Apology issued over 'truly appalling' NHS Forth Valley CAMHS figures

Call for patience as NHS continues to feel strain
Health chief's plea in face of staff absences

Local people across Forth Valley are being asked for their ongoing patience and support by health bosses as GP and other primary care services come under increasing pressure due to an increase in Covid-19 related staff absences.

NHS Forth Valley chief executive Cathie Cowan said: "GP practices have and continue to play a key role in the NHS response to the pandemic and I would like to thank all staff working in primary care and other community services across Forth Valley for their tremendous efforts over the last 18 months to support patients and their families.

"The ongoing impact of the pandemic and the recent high levels of Covid-19 related staff absences not only impacts on the delivery of hospital-based care, but also on the ability to deliver important community health services, including those provided by staff in local GP practices, pharmacies, dental practices, and opticians.

"We are therefore working closely with our colleagues in primary care so that we can respond quickly to changing service and workforce pressures."

NHS Forth Valley deputy medical director for primary care and local GP Dr Scott Williams said: "It is important to request local people that GP practices and other primary care services are still here for them, but some services or opening hours may be affected as temporary staff cover the short-term needs of the service. We know any changes to existing services can be frustrating, especially if they have to be made at short notice, and we really appreciate the public's support and understanding.

"We ask people to treat them with respect and be kind as they continue to support patients."

Dr Scott Williams

All local primary care and community health services have contingency measures and plans in place to deal with service and staffing challenges and are continuing to follow current guidelines. People are asked to plan ahead, where possible, and to be aware that it may take longer than normal to deal with more routine tests and appointments.

GP practices reception staff can book appointments with other members of the practice team including mental health nurses, physiotherapists, and advanced nurse practitioners where appropriate to patient needs. Local pharmacies can also provide health advice and, under the Pharmacy First scheme, provide free treatment for many common health conditions without the need for a GP prescription.

NHS Forth Valley provides a wide range of health information and advice and the NHS Information Line can also be contacted on 111 (24 hours, seven days a week from 8am to 8pm).

A&E treatment times fall short of targets
New figures have revealed that just under two-thirds of A&E patients in Forth Valley were seen within four hours in the week to February 20.

The latest data from Public Health Scotland reveals that 1,094 people were seen within the region's accident and emergency units for the seven-day period - with 389 of these seen within the guideline mark.

It means 64.4 per cent of patients were seen within the four-hour target, well below the 95 per cent outlined as a national guideline and also a fall on recent monthly data which showed an improvement in Forth Valley's treatment times towards the target.

The figures do show a sharp increase in the numbers treated by eight hours waiting time - at 57.1 per cent, even within that time period.

The weekly data follows a rise in A&E waiting times for Forth Valley recorded in the month-by-month numbers, which reported 77.6 per cent of patients being seen within four hours for January 2022, compared to 68.4 per cent for the last month of 2021.

Local figures were reflective of the wider trends seen across Scotland, with only three health boards - Tayside, Western Isles and Shetland - coming close to beating the 95 per cent treatment time guideline within four hours in January this year.

The January A&E four-hour treatment time for Forth Valley was also higher than the national average across Scotland, with NHS Scotland recording a total of 7.6 per cent of people being seen within the target time.

Figures Forth Valley Royal

Spike in Omicron isolation cases sparks workforce Covid crisis across essential services

Ana leads the way for more Spanish nursing students
By Raymond Bakonyi Reporter

SPANISH healthcare workers flooded the Forth Valley thanks to the efforts of a student nurse.

Ana Castella, a student nurse in the Day Medicine Unit at Forth Valley Royal Hospital, is helping to bring Spanish nurses to the UK and abroad to get in touch for support if they are considering a move to the UK.

She was part of a group of healthcare workers, mainly nurses, who recently set up the 'Ibiza' social association of Spanish Nurses and Healthcare Workers in a bid to provide advice and guidance.

Ana, who is set to graduate in May 2022, said: "I moved to SHIP in 2013 because of my husband's job."

A CALL: Ana Castella moved to SHIP in 2013 and is set to graduate as a nurse this May, having served as a day nurse at Forth Valley Royal Hospital.

"However, my team and I have been very lucky to have trained in NHS Forth Valley and would like to help more nurses to come and work here."

The association, named in honour of an inspirational Spanish nurse who supported efforts to eradicate malaria through vaccination in the early 19th century, is helping to reverse the decline in recruitment from Spain since 2017.

Indeed, figures from the Nursing and Midwifery Council show that the total number of people on its register who first trained in Spain dropped 50 per cent between September 2016 and March 2021. From 1,265 to 640.

Ana added: "I've personally felt very welcome in Scotland and believe it is one of the best places in the world to develop a health service."

Staff absences at Forth Valley Royal lead to 'concerns' over diagnostic services

SOCIAL MEDIA



NHS Forth Valley's social media platforms have continued to be used extensively to provide quick, clear advice and information as well as signpost people to local services and support throughout the Covid-19 pandemic.

Social media audiences continue to grow and NHS Forth Valley now has over 29,389 followers on Facebook, more than 16,900 followers on Twitter and a growing audience on Instagram.

Over the last few months, the Communications Department has worked closely with colleagues from the Scottish Government, Public Health Scotland and NHS 24 to support a number of national campaigns. These included campaigns to promote Covid-19 and flu vaccinations, address vaccine hesitancy, encourage regular LFD testing, support mental health and wellbeing and reduce the stigma associated with drug and alcohol dependency. Campaigns to highlight living kidney donation, cervical screening and other national screening programmes were also promoted locally.

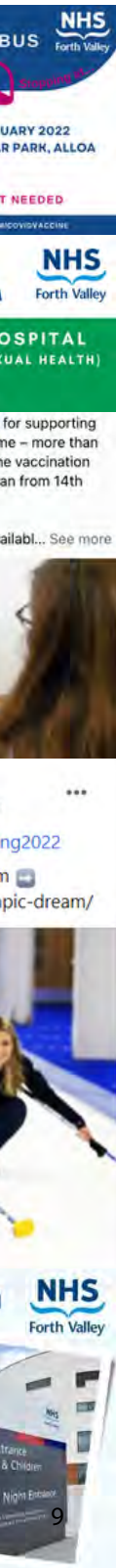
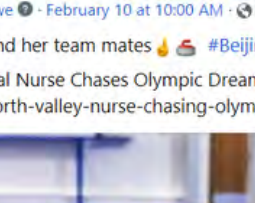
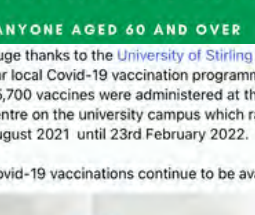
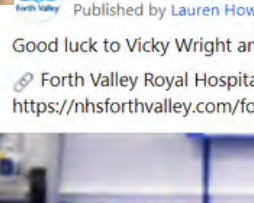
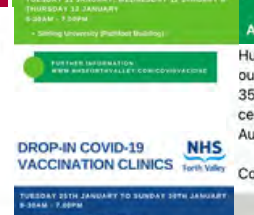
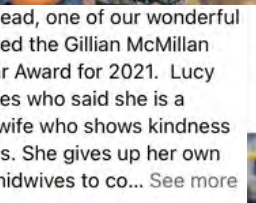
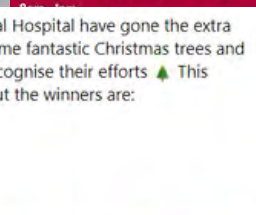
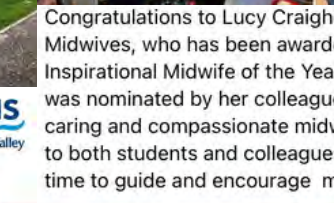
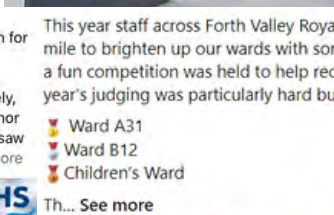


SOCIAL MEDIA



Local information and updates were regularly shared across our social media channels during the period. This included activity to highlight new Covid-19 drop-in and mobile vaccination clinics across the Forth Valley area, highlight new ways of accessing urgent healthcare advice and treatment and promote alternatives to attending the Emergency Department at Forth Valley Royal Hospital.

Weekly 'Feedback Friday' posts continue to highlight positive feedback from local patients and their families along with a regular posts to promote local job opportunities across NHS Forth Valley and local staff achievements.



DIGITAL DEVELOPMENTS

NHSFORTHVALLEY.COM

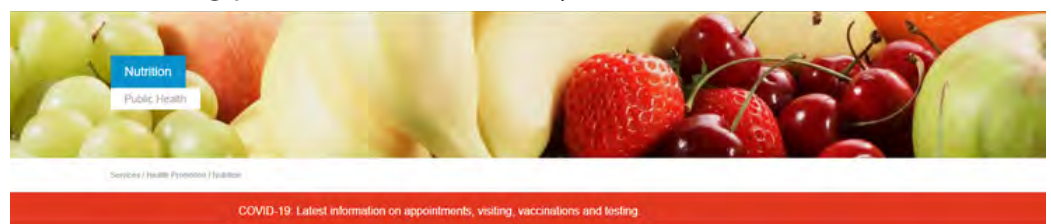
Between November 2021 and March 2022, there were 842,695 total views on our website with Covid-19 vaccinations, Covid-19 testing, flu and booster vaccinations among the most popular pages visited.

On average there are around 52,000 visits a week to the NHS Forth Valley website.



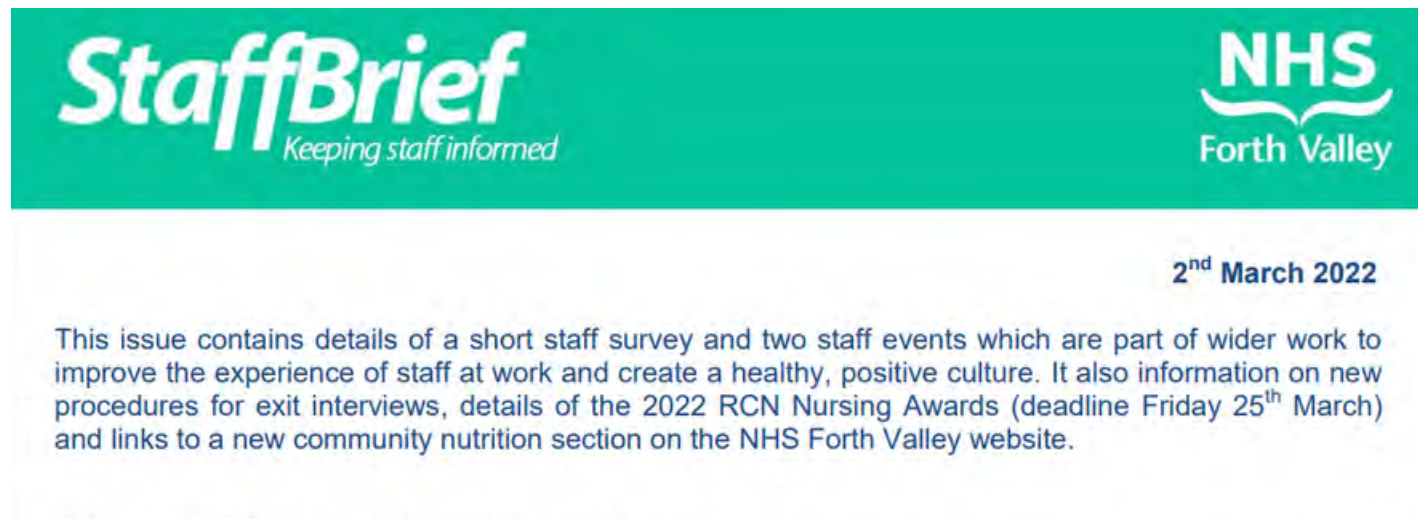
NEW COMMUNITY NUTRITION SECTION

A new community nutrition section developed on the website (www.nhsforthvalley.com/nutrition) attracted 10,618 total views during the period. It covers 17 different topics including nutrition advice for babies, children and older people, a multicultural nutrition section and advice on how to eat more sustainably and reduce food waste. There are also links to the popular Choose to Lose weight management website, a new grow and cook page as well as details of local food groups, grants and funding opportunities. A case studies section showcases some of the food-related initiatives taking place across Forth Valley.



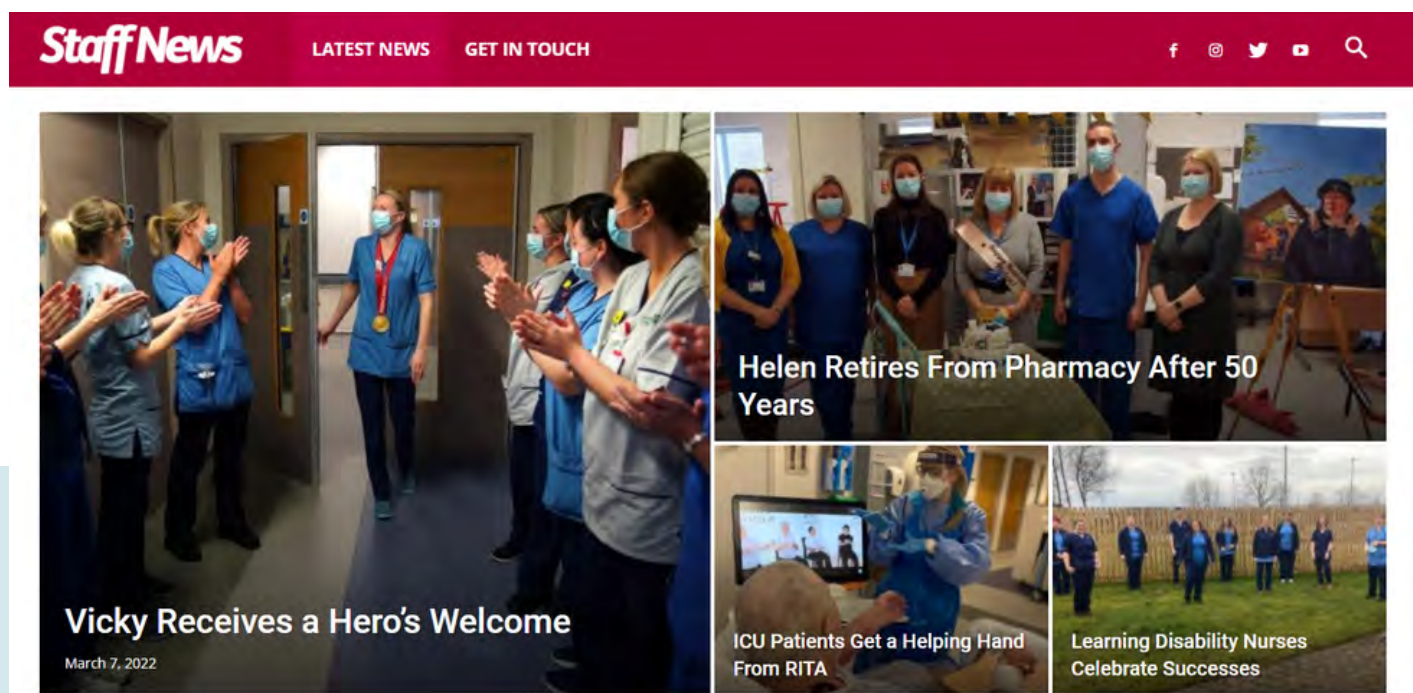
INTERNAL COMMUNICATIONS

Work continues to ensure staff are kept up to date, with daily updates on the homepage of the staff intranet, regular Staff Briefs which are emailed out to all staff and monthly staff newsletters.



STAFF NEWS

Staff News continues to be published as a regular online bulletin (<https://staffnews.nhsforthvalley.com>) with key highlights emailed to all staff and promoted individually on the home page of the staff intranet . This means the newsletter can be easily viewed by all staff anywhere, anytime on a computer or mobile device.



FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

9.2.1 Performance & Resources Committee Update – 01 March 2022
For Assurance

Chair: Mr John Ford, Non-Executive Board Member

The agenda item below was approved by the Performance & Resources Committee:

- **Item 6.1 Sustainability Loan – Tillicoultry Health Centre**

It was noted that the national GP Sustainability Loan Scheme was introduced by the Scottish Government in 2018, and that detailed guidance on the policy, process and provisions of the GP Loan scheme is set out in Scottish Government circular DL(2018)22.

The Performance & Resources Committee was advised that Tillicoultry Medical Practice had made an application for a loan and that the request had met the applicable criteria set out in the Scottish Government circular.

Following discussion Mr Urquhart confirmed that the lender is Scottish Ministers, through the Health Board, and that funding for the loan would be provided by Scottish Government, to be repaid on the basis set out in the circular. Accounting transactions would be made in line with detailed guidance prepared by the NHS Technical Accounting Group.

In relation to the Health Board's role on the GP loan application process it was confirmed that the Health Board would record and receipt the application and confirm that necessary information and documentation requirements had been met and verified. The decision on loan approval would be made by the Scottish Government.

It was noted that this application was the first of a number of GP practices in Forth Valley to reach this stage of the process and others were still in progress, both locally and across the rest of Scotland.

Key points to note from the meeting:

- **Item 7.1 Community Planning Partnership Update**

It was highlighted that Scottish Government statistics estimated that 19% of the Scotland population were living in relative poverty after housing costs in 2017 – 2020. Before housing costs, 17% of the population (910,000 people) were living in poverty. It is estimated that 17% of the population (900,000 people each year) was living in absolute poverty in 2017 – 2020. The absolute poverty indicator providing a measure of whether incomes of the poorest households are keeping pace with inflation.

The percentage of working age adults in relative poverty is also 19% after housing costs. Before housing costs, 17% of the population were living in poverty. 14% of pensioners were in relative poverty after housing costs in 2017-2020 noting the poverty rate for pensioners has been consistently lower than that for working-age adults and children.

24% of children in Scotland were in persistent poverty after housing costs in 2017-2020. After a long fall in child poverty rates from the late nineties to 2010-2013, child poverty rates have been gradually rising again. 68% of children in poverty in Scotland live in working households in 2017-2020. Scottish Government child poverty priority groups are more likely to be in relative poverty compared to all children particularly for those in ethnic minority households, and those with a single parent

It was noted that Clackmannanshire, Falkirk and Stirling Community Planning Partnerships have focused on tackling poverty for a number of years and all three Local Outcome Implementation Plans have a strong emphasis on this.

Since initial scoping of a plan for Health Foundation's Economies for Healthier Lives funding in October 2020, NHS Forth Valley has moved at pace to develop the organisation's role as an anchor organisation to support local community wealth and health building. An Anchor Springboard Group had been established, with monthly meetings, to drive momentum to deliver a contribution based on the principles of local community wealth building. An anchor institution consortium would be set up in the near future further engaging with partners.

The Scottish Government Child Poverty Action plan is currently being refreshed and community planning partners will take cognisance of the strategic direction of this guidance in developing Local Child Poverty Action Reports for 2022 and beyond. Work has commenced with local partner child poverty leads and Public Health Scotland to develop a Public Health approach to better understand the local child poverty systems and pull together child poverty data sources to support improved child poverty partnership planning locally.

NHS Forth Valley continues to provide support to children's services planning with all three community planning partnerships. It was noted work was progressing at scale and pace across many services to tackle the socio-economic impacts of the pandemic.

- **Item 8.2 Cancer Services Update**

The Performance & Resources Committee received a presentation noting the Clinical Governance Routes for cancer Services and highlighting the Framework for Effective Cancer Management. The framework was refreshed and published in December 2021 and was noted to be central to achieving the 62-Day standard and would require collective collaboration between primary and secondary care. The Framework was noted to cover the eight key elements of, Corporate Responsibility, Optimal Referral, Initiating the Pathway, Dynamic Tracking & Escalation, Optimal Diagnostics, Effective MDT, Treatment, and Collective Strength, with the patient's needs at the centre. The framework would also serve as a benchmarking tool for Forth Valley Cancer services.

The Quality Performance indicators have recently undergone a review to further strengthen the existing governance process and provide a greater oversight and have been developed across tumour groups to drive continuous quality improvement within cancer services.

The indicators are underpinned by a Regional Annual Governance Process and improvement Framework. It was noted the new exception reports are now shorter and more focused allowing targeted discussion of key clinical exceptions identified during the analysis and clinical review of annual results. Tumour specific Clinical Leads from each tumour network will attend Regional Cancer Advisory Group meetings to discuss issues arising. The Quality Performance indicators were subject to an external review and quality assurance which was carried out by Healthcare Improvement Scotland.

Ms Bonnar highlighted Forth Valleys performance against the 62-day and the 31-day cancer standard. It was noted that Forth Valley consistently meet the 31-day standard but underperforming against the 62-day standard which is in-line with the rest of Scotland position.

NHS Forth Valley has continued to diagnose and treat cancer patients throughout the pandemic and have managed to continue the surgical pathway to good effect. A Clinical Governance Framework has been established for Cancer Services in Forth Valley with a Service Level Agreement agreed with NHS Lanarkshire to ensure the Head & Neck cancer service is sustainable.

NHS Forth Valley was currently placing bids with the Scottish Government to look at 3 session working within Endoscopy to increase capacity. It was noted that there was well established nurse endoscopists teams within Forth Valley which have been in post for several years.

Key challenges and opportunities were described with a request from Performance & Resources Committee that these be compiled into an action plan describing what is required to support a sustainable service to come back to the Performance & Resources Committee.

- **Item 9.2 Integration Joint Board 2022/23 Financial Planning**

The Integration Schemes for both Integration Joint Boards includes a provision for IJB annual business cases to be presented to constituent bodies for consideration. It was noted that the cases presented had been through an IJB approval process and presented financial planning assumptions for both IJBs in the Forth Valley area.

Discussions have been ongoing with Chief Finance Officers in respect of the budget uplift for health delegated functions for 2022/23. The proposed uplift was based on the conditions set out in the Scottish Government letter of 9 December 2021 from the Director of Health Finance and Governance to Chief Executives and IJB Chief Officers.

The letter stated that NHS payments to Integration Authorities for delegated health functions must deliver an uplift of 2% over 2021/22 agreed recurring budgets and make appropriate provision for increased national insurance costs. Updated calculations in respect of these payments, subject to NHS Board approval, have been shared with both IJBs and have been factored into the NHS Board financial plans.

Assurance was provided to the Performance & Resources Committee that NHS Forth Valley had applied the Scottish Government requirements in terms of the uplifts for the delegated health services. There has been regular correspondence between the NHS Board finance team and Chief Finance Officers and close partnership working in developing the financial planning parameters and inflationary cost calculations on budgets held within delegated health functions.

PERFORMANCE & RESOURCES COMMITTEE

Minute of the Performance & Resources Committee meeting held on Tuesday 18 January 2022 at 9.00am via Microsoft (MS) Teams

Present:	Mr John Ford (<i>Chair</i>) Mr Robert Clark Mrs Cathie Cowan Dr Graham Foster Mr Gordon Johnston Mr Stephen McAllister Ms Janie McCusker	Dr Michele McClung Mr Andrew Murray Mr Allan Rennie Cllr Les Sharp Mr Scott Urquhart Prof. Angela Wallace
In Attendance:	Ms Annemargaret Black Mrs Patricia Cassidy Ms Kirstin Cassells Mr Simon Dryburgh Mr Martin Fairbairn Ms Claire Giddings Ms Laura Henderson (Minutes) Ms Kerry Mackenzie	Ms Jackie McEwan Mrs Gillian Morton Mrs Kathy O'Neill Mr Jonathan Procter Mr John Stuart Ms Jilly Taylor Mrs Phyllis Wilkieson

1. DECLARATIONS OF INTEREST

There were no declarations of interest offered at this time.

2. APOLOGIES FOR ABSENCE

There were no apologies for absence intimated at this time

3. MINUTE OF PERFORMANCE & RESOURCES COMMITTEE MEETING HELD ON 26 OCTOBER 2021

The Minute of the meeting held on 26 October 2021 was approved.

4. MATTERS ARISING

There were no matters arising.

5. ROLLING ACTION LOG

It was noted that item one on the rolling action log featured on the agenda. Other items would be presented to the Performance & Resources Committee at a later date.

6. FOR APPROVAL

6.1 Parkview Medical Practice – Application to Redefine Practice Area

The Performance & Resources Committee received a paper, 'Parkview Medical Practice – Application to Redefine Practice Area', presented by Mrs Kathy O'Neill General Manager for Primary Care and Mental Health Directorate.

NHS Forth Valley received an application from Parkview Medical Practice in Stenhousemuir to redefine its practice area as described in its GMS Contract. The practice provides services from one location in Stenhousemuir and has approximately 5,070 registered patients.

It was highlighted that the Practice would retain existing patients who resided outwith the proposed redefined practice area and would continue to accept new babies or other family members of existing patients, who reside at the same address. New patients who reside outwith the proposed new practice area would not be accepted.

The proposal was discussed with the neighbouring practices. All practices responded with no issues or concerns in relation to the proposed change registered. NHS Forth Valley sought the views and recommendations of the Forth Valley GP Sub Committee as the professional advisory committee on 16 November 2021. The Committee offered no objections to the application and endorsed the proposal outlined in the application received from Parkview Medical Practice.

The Performance & Resources Committee:

- ***Approved the application to redefine practice area***

7. BETTER CARE

7.1 Unscheduled Care Update

The Performance & Resources Committee received a presentation 'Unscheduled Care in Forth Valley' led by Mr Andrew Murray, Medical Director supported by Ms Annemargaret Black, Clackmannanshire & Stirling IJB Chief Officer and Mrs Patricia Cassidy, Falkirk IJB Chief Officer.

Mr Andrew Murray provided background and context in terms of trend analysis data around the number of attendances at ED and the 4-hour standard compliance along with a comparison of other Health Board areas. An improving picture over recent weeks was noted.

The National Unscheduled Care Workstreams of, Redesign of Urgent Care, Interface, and Discharge without Delay were detailed with the local plan in dovetailing with this. The Acute Unscheduled Care Recovery Plan set out immediate actions with 30 day, 60 day and 90 day priorities with plans to embed refreshed systems aligned to the national workstreams. Key areas of focus included ED Flow 1 to achieve 100%; Flow 3 discharge without delay; Daily morning huddle in place reviewing safety, capacity, flow and site management; Escalation plan and implementation; Integrated discharge service; Redirection; Communication and Trajectory recovery.

A trend analysis showed the successful redirection of minor flow patients which had improved compliance with the overall 4-hour access standard.

Mr Johnston acknowledged the complexities involved and suggested an external communication to the Public to signpost patients prior to attending the Emergency Department may be helpful.

Following discussion, Mr Murray assured members that ongoing surveillance was carried out by the Head of Clinical Governance to ensure there were no adverse events or themes evident following redirection of care and work was ongoing to ensure the staffing and skill sets were appropriate to support timely patient care within the minor injuries department.

Mrs Wilkieson, Interim Director of Acute Services supported the work ongoing and advised that all acute management colleagues were on board with plans to deliver on priorities and stabilise the acute site position.

Mr Murray highlighted that NHS Forth Valley had previously successfully improved its position. It was important to get back to basics and repeat previous improvements ensuring a whole system approach.

Ms Black detailed the Health and Social Care recovery plan highlighting that unscheduled care happened across community and acute services. The number of initiatives taking place to support unscheduled care in the community and on the Acute Site were outlined. Short term business continuity was in place with longer term service redesign in progress.

Ms Black highlighted that the Unscheduled Care Programme Board had been re-established prioritising work focussing on prevention of admissions, improving internal acute processes, and discharge without delay.

Mrs Black added that Social Care was not seen as a desirable working opportunity which was making it difficult to recruit to posts.

It was noted that the Clackmannanshire and Stirling Health and Social Care Partnership had been shortlisted for a COSLA Excellence award in recognition of its multi-agency work to support care home residents and staff throughout the pandemic.

Mrs Cassidy presented detailed data in respect of Care at Home, system pressures and demand on community services within Falkirk Health and Social Care Partnership highlighting unmet need and complexity of care. Actions to optimise capacity were described however Mrs Cassidy added that acute delays only equated to about 40% of the current demand with a large proportion of activity being carried out in the community setting. High absence rates due to Covid were adding to the pressure to deliver care requirements.

The Performance & Resources Committee

- ***Noted the Unscheduled Care Update presentations***

8. BETTER HEALTH

8.1 Vaccination Programme Update

The Performance & Resources Committee received a presentation, 'Vaccination Programme Update', led by Mrs Gillian Morton, CPMO Director and supported by Mrs Jilly Taylor, Head of Service/Chief Nurse.

The presentation detailed the Covid Vaccination Programme progress and the Vaccination Transformation Programme.

The Booster by the Bells campaign had been fully supported. The approach taken by the vaccination team to ensure maximum Covid Vaccination coverage was detailed with a recent successful switch to a self-appointing portal which had reduced Did Not Attend rates. NHS Forth Valley had opted to distribute a reminder letter to those who had not yet self-appointed. A separate helpline had also been set up for those requiring travel vaccinations.

Covid Vaccination percentage coverage for 18+ years was noted as: First Vaccination 94.1%, Second Vaccination 90.9% and Booster or Third Vaccination 74.7%. The percentage coverage for 12+ years was noted as: First Vaccination 92.7%, Second Vaccination 87.4% and Booster or Third Vaccination 69.2%.

Scotland's vaccination schedule from Pregnancy to Adulthood was outlined highlighting the extent of the vaccination programme. Key dates for the transition of vaccination programmes were outlined.

Following discussion Mrs Taylor added there was no immediate issues with workforce and succession planning in place to mitigate any risk.

The Performance & Resources Committee:

- ***Noted the Vaccination Programme Update presentation***

9. BETTER VALUE

9.1 Finance Report

The Performance & Resources Committee received a paper, 'Finance Report', presented by Mr Scott Urquhart, Finance Director.

Mr Urquhart reported that the revenue outturn projection for 2021/2022 remained consistent with previous reports at break-even against the current projected annual budget of £770.9m. The in-year financial position to 30th November 2021 was a small overspend of £0.018m against a budget for the 8-month period of £476.621m.

Variability in workforce requirements and the associated cost of temporary supplementary staffing, given high staff absence rates coupled with sustained increase in hospital bed demand and patient care requirements was noted as a significant risk against projection as this had increased by over 50% on the previous year.

There were also three further potential risk noted against the reduction in diagnostic and clinical supplies costs as certain non-urgent procedures and services were postponed in order to maintain critical services, finalisation of anticipated funding allocations including National Treatment Centre costs and additional Covid-19 funds and level of financial commitment required for annual leave buy back and carry forward as at 31st March 2022 where staff had been unable to take annual leave due to service pressures.

The Capital outturn projection for 2021/22 was a break-even against the current projected annual budget of £12.3m, expenditure to November totals £4.9m and further spend had been committed within available budget aligned to Medical Equipment and Modular Build which will be reported over next 4 months. Recent discussions had taken place with Scottish Government colleagues on finalising options for the year-end.

Mr Fairbairn was looking for further detail to reconcile Table 4.1 with the paragraph on 4.3 and following discussion Mr Urquhart agreed to circulate further detail to explain the Integrated Joint Board set aside budgets in more detail.

The Performance & Resources Committee:

- ***Noted a projected break-even financial position against revenue and capital resource limits for 2021/22 year-end, subject to key risks highlighted in the report.***
- ***Noted an overspend of £0.018m for the eight-month period to 30th November 2021.***
- ***Noted the updated assessment of annual COVID-19 related costs and funding, with a further return to be submitted to Scottish Government in January.***

9.2 Financial Plan Update

The Performance & Resources Committee received a presentation, 'Financial Plan Update', led by Mr Scott Urquhart, Finance Director.

Mr Urquhart provided detail of the refreshed financial plan outlining the high levels of spend and the requirement to balance resources against costs. The strategic context was noted with issues in respect of the delivery of planned care noting backlog and demographic changes, unscheduled care delivery, integrated services and the future of services in living with Covid.

The impact of unavoidable cost increases in respect of pay inflation and price inflation were detailed along with additional investment in developments. Several service improvement initiatives had been identified and it was noted there had been cost improvement groups set up to drive saving efficiencies.

A further update would be presented to the Performance & resources Committee in March 2022.

The Performance & Resources Committee

- ***Noted the Financial Plan Update presentation***

10. BETTER GOVERNANCE

10.1 Performance & Resources Committee Assurance & Work Plan

The Performance & Resources Committee received a paper 'Performance & Resources Committee Assurance & Work Plan' presented by Ms Kerry Mackenzie, Head of Policy & Performance.

The Assurance and Work Plan outlined the key items of business the Performance & Resources Committee had to consider as part of its schedule of work for 2022/2023. The report was designed to capture key implications from papers presented, linking to the Performance & Resources Committee Terms of Reference and any associated Strategic Risks. It would support the committee to fulfil its terms of reference and the drafting of its Annual report.

Mr Procter highlighted that the Staff Governance Committee was undertaking a similar piece of work and that cognisance should be taken of this.

As a number of decisions were required in terms of identify how the committee would determine the levels of assurance required it was suggested this item be discussed at a dedicated Board Seminar. This would allow time for full engagement.

The Performance & Resources Committee:

- ***Noted the Performance & Resources Committee Assurance & Work Plan***
- ***Requested a dedicated session to review the Assurance & Work Plan and to agree progress this work***

10.2 Emergency Planning and Resilience Group Minutes: 26/08/2021

The Performance & Resources Committee received a paper, 'Emergency Planning and Resilience Group Minutes: 26 August 2021', presented by Dr Graham Foster, Director of Public Health & Strategic Planning

Mr Foster highlighted the key points for consideration from the Emergency Planning and Resilience Group Minute.

The Performance & Resources Committee:

- ***Noted the Emergency Planning and Resilience Group Minutes: 26 August 2021***

10.3 Information Governance Group Minutes: 23/09/2021

The Performance & Resources Committee received a paper, 'Information Governance Group Minutes 23 September 2021', presented by Mr Andrew Murray, Medical Director.

Mr Murray highlighted key points for consideration from the Information Governance Group Minutes and added that the Internal Audit assurance report would come to a future meeting.

The Performance & Resources Committee:

- ***Noted the Information Governance Group Minute: 23 September 2021***

11. FOR INFORMATION

11.1 Recovery & Performance Scorecard

The Performance & Resources Committee received a paper, 'Recovery and Performance Scorecard' which had been previously circulated on 23 December 2021 and was presented for information.

The Performance & Resources Committee:

- ***Noted for information only the Recovery and Performance scorecard***

11.2 Network & Information Systems Regulations Update

The Performance & Resources Committee received a paper, ' Network & Information Systems Regulations Update was noted for information.

The Performance & Resources Committee:

- ***Noted for information the Network & Information Systems Regulations Update***

12. ANY OTHER COMPETENT BUSINESS

There was no other competent business offered at this time.

13. DATE OF NEXT MEETING

Tuesday 1 March 2022 at 9.00am via MSTeams

FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

9.2.2 Audit and Risk Committee Minute – 21 January 2022
For Assurance

Chair: Cllr Les Sharp, Non-Executive Board Member

Minute of the NHS Forth Valley Audit and Risk Committee meeting held on Microsoft Teams on Friday 21 January 2022.

Present: Cllr Les Sharp (Chair)
Mr John Ford
Cllr Susan McGill
Mr Robert Clark

In Attendance: Mr Scott Urquhart, Director of Finance
Mrs Cathie Cowan, Chief Executive
Mr Tony Gaskin, Chief Internal Auditor, FTF Audit Services
Mrs Jocelyn Lyall, Regional Manager, FTF Audit Services
Ms Shona Slayford, Principal Auditor, FTF Audit Services
Mr Adam Haahr, Audit Scotland
Ms Kerry Mackenzie, Head of Policy & Performance
Mr Graeme Bowden, Capital Accountant

1/ APOLOGIES

Apologies for absence were intimated from Mr Stephen McAllister.

2/ DECLARATIONS OF INTEREST

There were no declarations of interest intimated.

3/ MINUTES OF PREVIOUS MEETING

The Minute of the Audit Committee meeting held on 22nd October 2021 was approved as a correct record.

4/ MATTERS ARISING – ACTIONS FROM PREVIOUS MEETINGS

4.1 National Shared Services – Payroll

Mr Urquhart provided the Audit and Risk Committee with an update on progress made in the South East Payroll Consortium programme. The Business Case for delivery of payroll services as part of the South East Payroll Services Consortium was approved at closed session on the NHS Board on 30th November 2021. The Audit and Risk Committee were informed that a paper outlining the next stages in the process would be presented to the Performance and Resources Committee in March 2022.

The Committee noted the update on the progress update on South East Payroll

5/ INTERNAL AUDIT

5.1 Internal Audit Progress Report

Mrs Lyall presented the Internal Audit Progress Report and highlighted that since the last meeting three final reports had been issued including the Internal Control Evaluation Report, presented separately at a later agenda item. In addition, one Integration Joint Board (IJB) report had also been issued. Mrs Lyall provided the Committee with a summary of Audit Findings.

Mrs Lyall updated the Committee on recruitment ongoing within the FTF Audit team and confirmed that a new Principal Auditor had been appointed and would be commencing in February 2022.

The Committee noted the Internal Audit Progress report.

5.2 Internal Audit Framework

Mr Gaskin presented the Internal Audit Framework paper that included an updated Internal Audit Charter and NHS Forth Valley Internal Audit Reporting Protocol. Mr Gaskin advised that within this review there were no material changes since the previous version of the Framework presented in October 2019. Mr Gaskin highlighted that the Internal Audit Charter was required to be approved annually by the Audit Committee.

The Committee noted the NHS Forth Valley Specification for Internal Audit Services and approved the updates to the Internal Audit Charter and the NHS Forth Valley Internal Audit Reporting Protocol.

5.3 Internal Control Evaluation

Mr Gaskin presented the Internal Control Evaluation (ICE) for 2021/22. Mr Gaskin advised that the ICE is produced to provide assurance on the system of internal control that supports the achievement of the Board's objectives in parallel with the Sustainable Services review, and Follow-up of previous recommendations. The report also set out progress against the following areas:

- Identification of emerging risks and key actions to manage high priority risks;
- Identification of the key risks and challenges to achievement of strategic objectives and ensured that progress is monitored at governance level;
- Identification of opportunities for change and improvement to develop and implement the organisation's strategic agenda;
- Implementation of revised arrangements to ensure NHS Forth Valley can effectively respond to COVID-19 and discharge its governance responsibilities; and
- Focus on key themes and actions arising from the Annual Internal Audit Report and findings on remobilisation.

Mr Gaskin gave an overview of the report and highlighted some of the positive developments during 2021/22, including the financial risk deep-dive exercise, and the key challenges ahead including risks related to an ageing workforce and ongoing challenges within Unscheduled Care. These however were national issues and not just relevant to NHS Forth Valley.

There was discussion on Section 13 of the report that recommended the ICE report should be shared with each Standing Committee and it was agreed that this should be progressed to share relevant findings and monitor actions.

The Committee noted the Internal Control Evaluation for 2021/22 and agreed that the report would be distributed to Standing Committees for consideration.

6/ EXTERNAL AUDIT

6.1 External Audit Progress Report

Mr Haahr confirmed that planning for the 2021/22 Annual Accounts process had commenced and system reviews were planned to be undertaken in February 2022. Mr Haahr asked the Committee to note that the statutory deadline for submission of annual accounts was currently set at 31st August 2022, and Mr Urquhart confirmed that his team were working on the timetable with Auditors with a view to conclude the process as early as possible.

Mr Haahr asked the Committee to note that this would be the final year of Audit Scotland's term as External Auditors to NHS Forth Valley, and the Board would be informed of the new audit team by Scottish Government.

The Committee noted the External Audit Progress update.

7/ AUDIT FOLLOW-UP

7.1 Audit Follow-Up Report

Mr Bowden presented the Internal Audit Follow-Up Report and reported that:

- 83% of Audit Actions due are complete or partly complete
- 5% of Audit Actions are not yet due for response
- 12% of Audit Actions were overdue for completion.

Mr Bowden confirmed that the Director of Finance had presented a paper to the Systems Leadership Team on 17th January 2022 setting out an overview of the current position of follow up actions and reinforcing the importance of addressing recommendations made within Audit Reports within the agreed timescales. The paper also outlined an update to the escalation process - where recommendations remain incomplete for more than three months beyond their due date, the responsible officer will be invited to attend the Audit and Risk Committee to provide an update.

Mr Ford asked if the RAG Status of outstanding recommendations could be added to the report and this was agreed.

The Committee noted the Audit Follow-Up Report.

8/ GOVERNANCE ISSUES

8.1 Best Value Framework

Ms Mackenzie presented the Best Value Framework paper and summarised the position against each of the following key themes:

- Vision and Leadership
- Effective Partnerships
- Governance and Accountability
- Use of Resources; and
- Performance Management

Ms Mackenzie highlighted that forward planner tool and template had been developed within Pentana and introduced to the Performance & Resources Committee in January 2022 for comment. The planner incorporates an assurance plan, linking risks to the responsibilities of the committee, and captures key information that supports the provision of assurance to the committee. The reporting functionality had been developed for roll out to NHS Board Assurance Committees.

The Committee noted the Best Value Framework update.

9/ COUNTER FRAUD SERVICES

9.1 Counter Fraud Services Quarterly report Quarter ending 30 September 2021

Ms Slayford presented the Counter Fraud Services (CFS) Quarterly Report for the period ending 30th September 2021 and highlighted that there had been one new referral made relating to NHS Forth Valley during the quarter. Ms Slayford highlighted that this new referral related to an allegation that an employee had been working while on sick leave, however following initial enquiries the case was closed by Counter Fraud Services. Ms Slayford also indicated that CFS responded to the increased risk of fraud, as a result of the Covid19 pandemic, by compiling a summary of all alerts on a rolling Covid19 document which is distributed by the Fraud Liaison Officer to relevant officers within NHS Forth Valley. The document includes tips on the prevention of procurement fraud and how to improve cyber security; themes have included: cyber security threats, scammers (COVID Passport, WhatsApp, Lost Pet, Phone; and Doorstep Scams).

Regarding Patient Exemption Checking, Ms Slayford indicated that for the period 1st April 2021 to 30th September 2021 NHS Forth Valley had made patient recoveries to the value of £9,964 that represented 4.4% of the Scotland wide total.

The Committee noted the Counter Fraud Services Quarterly Report for period ending 30th September 2021.

There being no further business the meeting closed at 9.50am.

10/ DATE OF NEXT MEETING

The next meeting of the NHS Forth Valley Audit Committee will take place on Friday 25 March 2022 via Microsoft Teams.

FORTH VALLY NHS BOARD

TUESDAY 29 MARCH 2022

**9.2.3 Staff Governance Minute – 10 December 2021
For Assurance**

Chair: Mr Allan Rennie, Non-Executive Board Member

Minute of the Virtual Staff Governance Committee meeting held on Friday 10 December 2021

Present	Mr. Allan Rennie, Non-Executive Director (Chair) Ms Janie McCusker (Board Chair) Ms Susan McGill, Non-Executive Director Mr Gordon Johnston, Non-Executive Director, (<i>Whistleblowing Champion</i>) Ms Janett Sneddon, RCM Mr Robert Clark, Employee Director Ms Karren Morrison, Unison
In Attendance	Mrs Cathie Cowan, Chief Executive Ms Linda Donaldson, Director of HR Mrs Elaine Bell, Interim Associate Director of HR Mrs Margaret Kerr, Head of Organisational Development Mrs Linda Robertson, HR Service Manager Mr Jonathan Procter, Director of Facilities & Infrastructure Mr Cameron Raeburn, Head of Health and Safety Ms Marian Smith, Personal Assistant (<i>Minute</i>)

1. Welcome and Introductions

Mr Rennie welcomed everyone to the meeting.

2. Apologies for absence

Apologies for absence were noted on behalf of Professor Angela Wallace.

3. Minute of Meetings

3.1. Draft minute of Staff Governance Committee meeting held on Friday 17 September 2021

The draft minute of the Staff Governance Committee meeting held on Friday 17 September 2021 was approved as a correct record.

3.2 Draft Minute of the Remuneration Committee held on Monday 12 July 2021

The Staff Governance Committee noted the draft minute of the Remuneration Committee held on Thursday 21 October 2021.

4. Matters Arising from the Minute

HR Directors Report - Work Life Policies

The consultation period of the supporting work life balance policies is detailed in the HR Directors Report at Item 7.2.

5. ED Review

The Staff Governance Committee received a verbal update from Mrs Cathie Cowan, Chief Executive.

Mrs Cowan reported that good progress was being made against the recommendations. A special Area Partnership forum had been held with a focus on the ED Improvement Plan and provided an opportunity for Staff Side to seek clarity and assurance regarding the implementation of the recommendations.

The Staff Governance Committee were advised that the recruitment process for the Clinical Nurse Manager and Education Facilitator had been successfully completed.

Ms McCusker provided an assurance to the Staff Governance Committee that the ED Oversight and Assurance Sub Committee continued to meet on a regular basis and noted the exemplary work of all those involved with ensuring the recommendations were being progressed. A monitoring process of completed actions will be implemented to ensure continued improvement and representatives from focus groups would be invited to attend the sub committee in due course.

The Staff Governance Committee: -

- **NOTED** the update

6. RISK MANAGEMENT

6.1 Health & Safety Quarterly Report – (Q2)

The Staff Governance Committee considered a paper 'Health and Safety Quarterly Report - Quarter 4 (January 2021 – March 2021)', presented by Mr Jonathan Procter, Director of Facilities and Infrastructure and Mr Cameron Raeburn, Head of Health and Safety

Mr Procter gave the Committee a brief introduction regarding the ongoing re-formatting of the report which included key points now being outlined at the start of the document. A discussion had taken place at the recent NHS Board meeting around control charts, and it was recognised these would be useful within this report for future iterations.

Focus would be required around training compliance, which was now being formally reported. It was anticipated this would be an area of focus for the Staff Governance Committee with a need for ongoing focus recognised. A new audit process had been introduced, with a 'light touch' report. Initial results and key themes were being seen.

Mr Raeburn providing detail around each of the key points noted within the paper. He advised that the key points from quarters one and two would be reviewed with a follow up report in quarter three.

The Health and Safety Executive had responded that they were satisfied with actions taken in response to their Notification of Contravention issued following an in-patient suicide in the Mental Health Unit. The recommendations had been implemented and learning from the incident was being taken forward

A total of 108 events involving staff who had tested positive for Covid had been reported under RIDDOR. Note was made of a significant number of Covid positive staff who have not responded to contact. These staff would be identified to Senior Managers for follow up.

The number of Adverse Events reported had decreased to 2758 from quarter one and the same quarter last year. The number of events waiting to be reviewed within the 9-day target was 22%, with 469 waiting more than three months which is a significant improvement on quarter 1 - , 37% and 684 events. 12 months had increased. Relevant departments and services would be escalated to Senior Managers.

Non clinical adverse events, which account for 70% of the total adverse events reported, with slips, trips and falls, and violence and aggression account for 72%, which was down from 80% in quarter one. There had been a decrease in the number of reported events for violence and aggression 19% in quarter one and 19% in quarter two.

Musculoskeletal related absences that had been reported in quarter one had been followed up. Of the 35 absences that were reviewed, four were considered to be work related.

Training compliance for in person manual handling and violence and aggression training was significantly lower than what was required. The need for staff to be released for training was highlighted.

The Health and Safety Advisers had carried out eight audits, in quarter two, as part of the control book audit programme. There was an average compliance rate of 57%. Note was also made of some managers requiring guidance around how to complete the control book. A guide has been prepared and added to the Control Book, so it was available at point of need.

The NHS Board had approved the Health and Safety Strategy and Governance Framework. One of the objectives was to ensure that Directorates and the Health and Social Care Partnerships have Health and Safety Committees in place. It was noted that good progress was being made in establishing these, within a proposed timeframe of end of December 2021. Reporting would be through the Health and Safety and Staff Governance Committee and provide assurance to the Committees and the NHS Board that risks, and mitigations were in place.

The Staff Governance Committee discussed the new format with actions being identified, the relaunch of the dedicated time of two days to allow staff to undertake statutory and mandatory training, the reasons for noncompliance with statutory and mandatory training, the lessons learned from the reporting of work related covid positive cases to minimise the spread, the move from classroom to competency based training for manual handling in order to make the training role specific and the increase in self harm events and associated reasons.

The Staff Governance Committee requested that Training Compliance should be stand alone agenda item at the next meeting.

The Staff Governance Committee: -

- ***NOTED the report and the o-going work in support of improving Health & Safety across the organisation***

7. STAFF GOVERNANCE STANDARD ACTIVITY

7.1 Staff Governance Committee Workplan and Monitoring Tool

Consideration was given to a paper 'Staff Governance Committee Work Plan 2021 – 2022,' presented by Linda Donaldson, Director of HR.

Ms Donaldson gave an assurance to the Staff Governance Committee that all reports as detailed within the paper had been presented to the Committee and gave a brief outline of the reports to be presented at the March meeting. The Workplan would be a standing agenda item going forward.

Ms Donaldson advised that a Staff Governance Assessment Tool had been drafted and would be circulated to Directors to complete in advance of the March meeting. This would provide further assurance to the Committee that progress was being made against the Staff Governance Monitoring strands.

In response to a question from Mr Robert Clark regarding the frequency of completing the Staff Governance Assessment Tool, Ms Donaldson advised that each Directorate had been asked to complete an action plan from the assessment tool. The action plan which would help identify areas for improvement and form part of the Directorate Performance Review meetings.

Mr Procter advised that the Health and Safety Annual Report would not be available for the March Staff Governance Committee.

The Staff Governance Committee: -

- ***NOTED the progress with the Staff Governance Workplan 2021 – 22***

7.2 HR Directors Report

The Staff Governance Committee considered a paper 'HR Directors Report', presented by Ms Linda Donaldson, Director of HR.

Ms Donaldson highlighted International recruitment, the successful recruitment of Zambian nurses to train and work in NHS Forth Valley and the implementation of the nationally agreed eRostering Solution in NHS Forth Valley as detailed in the paper.

Ms Linda Robertson advised that the 'Once for Scotland Workforce Policies Programme Board' had paused their programme of work in response to the current pressures. The implementation of the Flexible Work Location policy and development of Phase 2 of the workforce policies had also been paused until no later than April 2022.

She further advised that work was continuing in the Youth and Employability Framework.

Employability Leads

Discussions had taken place with Public Health Scotland and the Scottish Government to look at the possibility of funded Employability Leads for all NHS Boards. Boards had been asked by Local Employment Partners to work on a range of issues including: -

- Community Wealth Building: NHS Boards to become inclusive Anchor Institutions/Health and Social Care Anchors
- Child Poverty Duty and Local Action Plans
- Fairer Scotland Duty and Equality Duty
- Support for the Young Persons Guarantee (part of No One Left Behind)
- Fair Work First (from 2022/23)

Initial discussions had taken place at local level with the three local employability partnership leads on how to build capacity to enhance Forth Valley's employability offer.

Ms Robertson highlighted the work in relation to the anchor institution, future recruitment marketing campaign, parental employment support fund, work placements, the modern apprenticeship programme and project search as detailed in the paper.

Ms Robertson reported on the October 2021 absence position. Absence had increased by 0.05% during October from 6.50% in September to 6.55% in October 2021. The Directorate absence summary, top reasons for absence by Directorate and summary by job family were detailed in appendix one of the paper. The NHSScotland absence figures were detailed in appendix 2 of the paper and a highlight report of NHS Forth Valley's workforce was detailed in appendix three of the report.

The Staff Governance Committee discussed the top reasons for absence as detailed in the paper and the daily Covid related absence reporting.

Ms Donaldson advised that weekly partnership meetings and monthly Workforce Performance Reporting meetings had been established. These meetings provided the opportunity to discuss any 'red flag' and hot spot areas in detail. The Staff Governance Committee requested time be set aside at the next meeting to look at the management of absence.

Mrs Bell advised that all managers were encouraged to attend a training session on absence management to ensure consistency of approach across NHS Forth Valley. Since October 2021 260 managers had attended these sessions which had resulted in a positive impact on the reporting of absence.

The Staff Governance Committee: -

- ***NOTED the content of the paper***

7.2.1 Staff Support and Wellbeing including Healthy working Lives

Ms Donaldson advised that it was anticipated that the Corporate Wellbeing Strategy would be issued for comment by the end of December prior to a more formal consultation. The Corporate Wellbeing Strategy would be presented to the Staff Governance Committee for final comment. It would also be submitted to a future Area Partnership Forum and Area Clinical Forum. An action plan would be attached to the strategy with links to the Sturrock Action Plan and Workforce Strategy.

The Staff Governance Committee received a presentation 'Corporate Wellbeing Strategy,' presented by Ms Rachel Tardito, Management Trainee.

Ms Tardito highlighted the work to date on the staff health and wellbeing agenda since March 2020 and the collaborative work to provide support services for staff.

Ms Tardito reported on the work in relation to the corporate wellbeing strategy which was based on the five strands of the staff governance standard. The strategy would ensure the goals as detailed in the presentation were met, it includes immediate and longer-term support and initiatives for staff wellbeing and it would focus on the four pillars of wellbeing to provide direct benefits to our workforce: -

- Emotional/Psychological Support
- Social
- Physical
- Financial

A workplan based on the four pillars would be attached to the strategy.

The Staff Governance Committee discussed the continued work around staff health and wellbeing, the links to the patient safety agenda, the relaunch of the Health Working Lives Group, the need for effective communication around the strategy, the signposting of staff to the wellbeing resources that are available.

The Staff Governance Committee: -

- ***NOTED the presentation and the work to date on the staff support and wellbeing programme***

7.2.2 Post Sturrock Action Plan

The Staff Governance Committee received a presentation 'Post Sturrock Review Group,' presented by Ms Linda Donaldson.

Ms Donaldson highlighted the actions, priorities and a progress update against each priority as detailed in the presentation.

The Staff Governance Committee welcomed the update on progress with the post Sturrock Review. There was a discussion on the exit interview process, lessons learned from exit interviews that had been carried out, the identification of red flag and the importance of

addressing these areas and any associated issues or concerns, the importance of capturing 'green flag' and sharing areas of best practice and the need to encourage more people to train as job evaluators to gain a better understanding of the process.

The Staff Governance Committee: -

- **NOTED** the presentation

7.3 Our People Strategy – Update on Progress

Consideration was given to a paper 'Our People Strategy 2018 – 2021: A Progress Update,' presented by Ms Linda Donaldson, Director of HR.

Ms Donaldson advised that the strategy was due to be revised in 2021 and highlighted the links to the post Sturrock Report Action plan and the Healthcare Strategy which was also due to be reviewed.

Ms Donaldson further advised that the national workforce strategy was due to be issued by the end of December 2021. The national workforce strategy would be aligned to the delivery of the workforce aspects of the remobilisation plan and national workforce planning activities. It was anticipated that the timescales for this would change to June/July 2022, therefore the review of the Healthcare Strategy and Our People Strategy would be paused until then.

Work is underway to support the review of the Healthcare Strategy with regular reports to the Corporate Management Team.

The Staff Governance Committee:

- **NOTED** progress made against Our People Strategy 2018 - 2021
- **NOTED** Our People Priorities next steps and future activity planned
- **NOTED** the impact of the COVID-19 Pandemic on the workplan and the requirement to review and reinvigorate a number of our actions
- **NOTED** that Our People Strategy 2018 - 2021 is due to be refreshed and with work underway this will be completed by December 2021 and thereafter presented to the Staff Governance Committee for approval

7.4 Update on Organisational Development Priorities including Learning, Education and Training and iMatter

Consideration was given to a paper 'Update on Organisational Development Priorities, including Learning, Education and Training and iMatter,' presented by Mrs Margaret Kerr, Head of Organisational Development.

Mrs Kerr highlighted the recent iMatter results. NHS Forth Valley had a response rate of 54% and an Employee Experience Index of 7.3. Overall, this was a positive position.

The Staff Governance Committee discussed the iMatter response rate, who could access team reports and action plans, the need to ensure action plans were completed and agreed, the need for confidentiality and the importance of the iMatter survey.

Mrs Kerr further highlighted the organisational development plan to support the emergency department (ED) and Labs.

Focus groups had been held for ED staff to seek their views on their support and development needs which would inform the development plan. Approximately 40 members of staff expressed an interest in attending the focus groups, however, only 13 members of staff participated. The themes have been collated to the development plan.

The recruitment to the Nurse Director in ED had been completed successfully and the ED clinical development plan had been drafted. The updated organisational development and Clinical education plan would be circulated for review and comments. A series of one-to-one meetings had been planned to enable staff to discuss their individual support and development needs.

Focus groups had been arranged for Labs to obtain their views on their support and development needs to inform the organisational development plan for each area. All proposed support had been agreed in partnership.

The Staff Governance Committee: -

- **NOTED** the paper and requested future updates on these and other areas

7.5 National Whistleblowing Standards – Update

Consideration was given to a paper 'Whistleblowing Standards and Activity Report,' presented by Mr Gordon Johnson, Non-Executive Board Member and Whistleblowing Champion.

The Staff Governance Committee were advised that the paper presented identified the quarter 2 report for the whistleblowing standards and provides assurance to the Staff Governance Committee on the continued implementation of the standards and the actions being taken to assist staff raise any concerns.

Mr Johnson advised that Whistleblowing Oversight Group had developed and implemented key performance indicators (KPIs) which had been included in the report to help identify the areas being developed.

Mr Johnson reported that reporting levels remained low and where colleagues have raised concerns the correct processes had been followed. Those staff members who had raised concerns using the whistleblowing policy, had been kept information of the actions being taken to resolve these.

Mr Johnston highlighted the links to the Speak Up initiative, the Speak Up Ambassadors and Advocates as confidential contacts and that there are no major issues that required to be addressed.

The Staff Governance Committee: -

- **NOTED** that the ongoing delivery of the standards is on trajectory.
- **NOTED** the Whistleblowing standard reporting in line with national requirements (KPI's)
- **NOTED** Whistleblowing activity in NHS Forth Valley in Quarter 2 of 2021

7.6 Speak Up Initiative - Update

Consideration was given to a paper, 'Speak Up – Update,' presented by Mrs Elaine Bell, Associate Director of HR.

Mrs Bell advised that the proposed launch date for the Speak Up initiative was week commencing 13 December 2021. A meeting had been held with the Chief Executive, HR Colleagues and the Speak Up team to discuss the initiative and practicalities for the launch.

The Speak Up Standard Operating procedure had been drafted along with a governance policy which outlined the governance arrangements that would be in place to ensure a confidential and impartial service that allows those receiving support through the Speak Up initiative is managed in a safe, fair and supportive manner.

A monthly Speak UP oversight group had been established, chaired by the Director of HR. A follow up meeting with the Director of Nursing, Ambassadors and Advocates had been arranged to discuss and agree the key role that Speak Up will have in the whistleblowing procedure.

The Staff Governance Committee acknowledged the project, the proposed launch date and the governance structure that had been put in place.

The Staff Governance Committee: -

- **NOTED** the progress and plans contained within the paper

8 REPORTS FROM COMMITTEES

8.1 Area Partnership Forum – 5 November 2021

The Staff Governance Committee noted the minutes of the Area Partnership Forum held 5 November 2021

8.2. Health and Safety Committee – 26 August 2021

The Staff Governance Committee noted the minutes of the Health and Safety Committee meeting held on 26 August 2021.

8.3 Facilities and Infrastructure Partnership Forum – 12 August 2021

The Staff Governance Committee noted the minutes of the Facilities and Infrastructure Partnership Forum held on 12 August 2021.

8.4 Joint Staff Forum – Clackmannanshire & Stirling - 29 July 2021

The Staff Governance Committee noted the minutes of the Clackmannanshire & Stirling Joint Staff Forum held on 29 July 2021.

8.5 Falkirk Joint Staff Forum – 29 July 2021

The Staff Governance Committee noted the minutes of the Falkirk Joint Staff Forum held on 29 July 2021

8.6 Mental Health and Learning Disabilities Partnership Forum – 28 September 2021

The Staff Governance Committee noted the minutes of the Mental Health and Learning Disabilities Partnership forum held on 28 September 2021.

8.7 Staff Support and Wellbeing Programme – 21 October 2021

The Staff Governance Committee noted the minutes of the Staff Support and Wellbeing Programme held on 21 October 2021

9. ITEMS FOR NOTING

9.1 Circulars and Policies

The Staff Governance Committee noted the circulars and policies as detailed in the paper.

10. ANY OTHER COMPETENT BUSINESS

Monitoring of Workforce Aspects in the Remobilisation Plan

Ms Donaldson advised a recommendation for the internal audit report was that the Staff Governance Committee would receive regular updates on the workforce aspects of the remobilisation plan with attention focussed on Directorate workforce planning activity.

COVID -19 New Variant

Mrs Cowan advised following discussion at the recent Chief Executives meeting on the impact on services of Covid-19 the Systems Leadership Team would discuss, in partnership, the requirement to step down non-essential services due to current demand on services.

Redeployment of Staff

It had been proposed to re-establish the redeployment hub for a period of time with services being asked to identify staff who could be redeployed to other areas whilst still maintaining services and being thoughtful about staff health and wellbeing.

Festive Season

A communication would be issued, from the Chief Executive and Director of Public Health, reminding staff to be extra careful in the run-up to the festive season, due the number of people contracting COVID including the Omicron variant, following having close contact at parties and nights out, where work rules don't apply.

There being no other competent business the Chair closed the meeting at 12 noon.

11. DATE OF NEXT MEETING

Friday 18 March 2022

FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

9.2.4 Clinical Governance Committee Update – 22 February 2022
For Assurance

Chair: Dr Michele McClung

Key points to note from the meeting:

Section 5 – In our services, Is Care Safe Today?

- **Item 5.1 COVID-19 Risk Assessment**
Mrs Bennie gave an update to the committee.

Section 6 – In our services, Was Care Safe in the Past?

- The agenda items in section 6 are reports and presentations which are standard items on the CGC agenda. These reports contain key safety metrics and narrative which provides assurance of the overall safety in our services. The reports presented at this meeting were:

Item 6.1 – Safety and Assurance Report November 2021 – December 2021

Mr Murray gave an update to the committee

Item 6.2 – Hospital Standardised Mortality Ratio (HSMR) Review & Clinical Outcomes Group (COG) update

The committee received an update on the Forth Valley HSMR position and the National HSMR position for Scottish Hospitals as a comparator. The COG priorities and quality improvement activities related to patient safety were also presented to the committee.

Item 6.3 – Cancer update

Dr Milling-Smith updated the committee with the FV cancer performance including the 31 and 62 day cancer targets

Item 6.4 – HAI Quarterly Report – October 2021 – December 2021

Mr Horwood updated the committee on the detail within the report

Item 6.5 - Standards and Reviews Report July 2021 – August 2021

Mrs Bennie gave an update to the committee

Section 7 – In our services, Will Care Be Safe in the Future?

- **Item 7.1 Risk Management**
There was no update at this meeting

Section 8 – Is Our Care Person-Centred?

- **Item 8.1 NHS FV Complaints and Feedback Performance Report November 2021**
The committee received an update of the detail within the report

Section 9 – Are We Learning and Improving?

- **Item 9.1 Significant Adverse Event Report**

Ms Lamont gave an overview of the Significant Adverse Event Reviews currently being undertaken including the timescales in relation to the Scottish framework

Section 10 – Are Our Systems Reliable?

- **Item 10.1 ED Review – Improvement Plan Recommendations**

Mr Murray updated the committee with the recommendations and progress to date

Section 11 – Further Assurance

- **Item 11.1 Clinical Governance Committee – Draft Annual Report/Forward Planner**

The committee was asked to comment on the draft CGC annual report and forward planner

- **Item 11.2 Clinical Governance Committee – Draft Terms of Reference**

The committee was asked to comment on the draft terms of reference

Section 12 – Reports from Associated Clinical Governance Groups

- **Item 12.1 Minute of Clinical Governance Working Group Meeting – 01.12.21**
- **Item 12.2 Minute of Organ Donation Committee meeting – 15.09.21**
- **Item 12.3 Minute of Child Protection Action Group meeting – 01.12.21**
- **Item 12.4 Minute of Child Protection Action Group meeting – 11.11.2021**

Section 13 – Any Other Competent Business

- **Item 13.1 Internal Control Evaluation**

Clinical Governance Committee

Minute of the Clinical Governance Committee held on 16 November 2021 at 9.00am via Microsoft (MS) Teams

Chair: Dr Michele McClung, Non-Executive Board member

Minute of the Clinical Governance Committee Meeting held on Tuesday 16th November 2021 at 9am via Teams

Present

Mr Andrew Murray, Medical Director (chair)
Mrs Helen McGuire, PPP Member
Mr Allan Rennie, Non-Executive Member
Gordon Johnston, Non-Executive Member
Kirstin Cassels, Chair ACF / Non Executive Member
Professor Angela Wallace, Nurse Director

In Attendance

Cathie Cowan, Chief Executive
Janie McCusker, Chairperson
Mrs Lynda Bennie, Head of Clinical Governance
Mr Jonathan Horwood, Infection Control Manager

Presenting

Mr Andrew Gibson, Head of Risk Management (item 7.1)
Mrs Elaine Kettings, Head of Patient Relations (item 8.1)
Ms Olwyn Lamont, Clinical Governance Manager (item 9.1)
Dr Kate Patrick, Director of Medical Education (item 12.2)

1. Apologies for Absence

Apologies for absence were received from Michele McLung, Graham Foster and Scott Mitchell

2. Declaration (s) of Interest (s)

There were no declarations of interest were noted.

3. Minute of NHS Board Clinical Governance Committee meeting held on 24 August 2021

Agenda item 1

Apologies from Angela Wallace was omitted from the minute, to be added.

4. Matters Arising from the Minute/ Action Log

Action Plan reviewed by the committee and updated.

5. In Our Service, is Care Safe Today?

5.1. COVID-19 Risk Assessment

LB discussed the measures taken during COVID to support capacity on site, linked with Andrew Gibson, AW and others to ensure risks were mitigated and safety was maintained. Standard Operating Procedures and risk assessments are in place. Operational risks are now on a live system.

Care Homes and Community Hospitals are included in risk assessments and representatives from each attend the Clinical Governance Working Group meetings. HM note that the ambulance service has experienced extreme difficulty, AM advised that there is engagement with the service which is monitored through the CGWG and clinical colleagues.

The Clinical Governance committee:

- Thanked LB for the report

6. In our Services, Was Care Safe in the Past?

6.1 Safety and Assurance Report April – June 2021

AM advised HSMR performance remains satisfactory. Cardiac Arrest Rate is fluctuating, meeting with the Resus team to review and improve the position, all cardiac arrests are fully investigated, and the team is actively working with the Deteriorating Patients group also reviewing the whole pathway to ensure any deteriorating patient is picked up and escalation of care is commenced. Monitoring the stroke bundle compliance through the Clinical Outcomes group. No patient waited longer than 24hrs for access to ICU. FV has the best performance in Scotland in relation to compliance with pressure ulcer.

AW advised that patients are oxygenated face down for the best possible outcome, however this caused some infections, and the team is working hard to prevent this. Oxygenating patients this way is a new phenomenon due to COVID and is a change in approach to nursing care.

AM advised NEWS2 is being rolled out across the organisation which will in the future include an automated alert element. Working with the national team on Falls Collaborative.

Overall, the data remains static and a range of work is ongoing to improve.

The Clinical Governance Committee:

- **Consider developing a dashboard to review data**
- **Noted the HSMR was satisfactory**
- **Cardiac arrest rate requires ongoing focus**

6.1.1 Stroke Bundle Focus

LB advised the Scottish National Audit Programme contacted FVRH to share Thrombolytic improvement work with other hospitals. Meeting with key leads to take further work forward, stroke bundle is reviewed through the Clinical Outcomes Group.

The Clinical Governance Committee:

- **Include target compliance, FV position and Scottish position for perspective**

6.2 HAIRT Quarterly Report – July 2021 to September 2021

JH advised the committee FV were performing well from a national perspective in relation to SAB. Four Hickman line infections reported, no areas of commonality identified. The majority of data points are below the Mean, investigating gut organisms further. No concerns with cDiff, 7 reported in the quarter were predominantly healthcare related. Expect challenges around achieving the AOP target. Four SSIs reported, same as the previous report, no national comparative data. One death reported with cDiff mentioned. No outbreaks reported in the quarter. Successfully recruited a number of staff into care homes and although there is a demand for experienced infection control nurses, two have joined the team. Looking to include data on care homes going forward. AW advised increasing the number of care assurance visits.

The Clinical Governance Committee:

- **Noted the report**
- **Include care home information to build confidence from a public perspective**

6.3 Standards and Reviews Report – July 2021 to August 2021

LB advised actively reviewing websites to identify and include relevant standards in this report. There is a system in place to share reports with teams for further dissemination to staff. Expect to streamline the report when additional staff are recruited to the team.

The Clinical Governance Committee:

- **Include HSCP work in this report**

7. In Our Services, will Care be Safe in the Future? (Andrew Gibson)

7.1 Risk Management Quarter 2 – update

AM advised that further improvement plans through the Unscheduled Care pathway are ongoing, AG noted that these will be included as this report develops. A deep dive is presented to the Performance and Resources Committee. Looking at a trajectory for each risk to identify how the risk is reduced. JM noted need to ensure mitigation is in place. CC advised ED is currently too small for the numbers attending, looking at contingency accommodation, also noted gaps in current staffing levels and rota's, and suggested developing models of care.

AM advised that reduced workforce was a constant theme throughout the reports. JM advised contingency plans were needed. HM recognised that both the hospital and staff were busy and suggested comms were engaged to make the public aware of the pressures. CC advised comms were actively engaged to inform the public on access pathways and pressures.

AM noted that cancer presentations reduced during covid, however in FV the position remained static and discussed the introduction of an accelerator pathways programme.

The Clinical Governance Committee:

- **Noted the report**

8. Is our Care Person Centred?

8.1 NHS FV Complaints and Feedback Performance Report – July 2021

(Elaine Kettings)

Eight cases presented to the SPSO, 5 were not taken forward, 82% of stage 1 complaints were not upheld and 62% of stage 2 complaints were not upheld. Working to improve performance on stage 2 complaints which is more complex cases, this is a symptom of system pressures and expecting this to dip further in the next report.

A bespoke questionnaire was developed for ED for patients and relatives, feedback from this will be shared with the committee. HM asked if volunteers could assist with the questionnaires to release staff time, EK advised need to consider the safety on site for volunteers and the feedback to staff directly was a valuable experience which motivated them due to the positive feedback.

The Clinical Governance Committee:

- **Noted the report and the work from the patient relations team throughout the pandemic to support other departments**

8.2 Person Centred Care Annual Report 2020 – 2021

AW advised the committee that the report was submitted to the Scottish Government on a yearly basis with no feedback.

EK advised the report included staff stories, feedback from staff and the initiatives implemented from the patient relations team to support patients to keep in touch with families when visiting was suspended.

The Clinical Governance Committee:

- **Paid tribute to the team for their work to support other departments throughout the pandemic**

9. Are we Learning and Improving?

9.1 Significant Adverse Event Report (Olwyn Lamont)

OL discussed the report, some refining within the system to be concluded, action plan and learning summary will be developed for the next meeting.

AM advised that the previous report into this Pentana style report, an action plan will be added to the historical reports for assurance.

The Clinical Governance Committee:

- **Noted the report was clear and tracks incidents**
- **Requested detail around non-compliance**

10. Are our Systems Reliable?

10.1 ED Review – Clinical Governance Recommendations

10.1.1 Cascade of Vincent Framework – Recommendation 6

AM discussed the recommendation which was shared on the intranet / staff brief, informed the committee that patient safety walk-rounds are carried out and suggested a more detailed review was undertaken.

The Clinical Governance Committee:

- **Noted the update**

10.1.2 Review of Clinical Governance – Recommendation 1

LB discussed the background to the recommendation, linking with FV Quality Strategy, designed a toolkit to adopt the principles of the framework and planned activities to deliver the framework. AM advised this should provide a detailed assessment of all levels of clinical governance which will be taken to the next Board meeting to agree and finalise timelines.

The Clinical Governance Committee:

- **Noted the update and requested accountability / responsibility was evidenced**

11. Reports from Associated Clinical Governance Groups (Ratified Minutes)

11.1 Minute of the Clinical Governance Working group meeting – 18.05.2021 Noted

11.2 Organ Donation Committee meeting – 02.06.2021

AR informed the committee the ODC was reviewing the memorial project, looking at a plan B for the sculpture due to challenges with air flow, cleaning and the fixing mechanism.

11.3 Minute of the Child Protection Action Group meeting – 04.05.2021

AW noted that the CPAG group had actually met twice since the meeting on 4th May. The group met on 10th September and 11th November 2021.

The Clinical Governance Committee:

- **Noted the above minutes**

12. Further Assurance

12.1 Adult Support and Protection Inspection update

AM advised NHS FV were asked to facilitate the 3 local authority inspections.

12.2 Medical Education Annual Report (Dr Kate Patrick)

KP presented the standards for training and advised patient safety was at the heart of training. There are 260 doctors in training, 269 medical students and 189 trainers and a budget of £1.6million to deliver the training. Each department has an Educational Lead and all doctors in training rotate yearly on the first Wednesday in August. Performance against the national standards was discussed, working to improve training in General Medicine and Trauma and Orthopaedics, it was noted that there were no areas which required enhanced monitoring. Only one day is set aside for the induction which includes introduction to 9 clinical systems and currently when Doctors change Health Board their e-mail address changes which causes additional issues – highlighting this at national level.

Part of care for the Doctors is ensuring that they get home safely after a night shift, and KP advised she had negotiated some overnight accommodation. A trainee forum has been developed and visits are now held in specific departments to engage with trainees. A clinician has been appointed as eHealth clinical lead.

The Clinical Governance Committee:

- **Thanked Dr Patrick for the presentation**

13. AOCB

13.1 Code of Corporate Governance Paper

AM advised the committee that this paper was for noting and awareness.

13.2 Membership of the Committee

AM advised currently recruiting to the Public Partnership Forum representative position vacated by Eileen Wallace. JM advised a paper is expected on committee membership across the Board.

14. Date and Time of the Next Clinical Governance Committee meeting

The next meeting will be held on Tuesday 22nd February at 9am via Teams

Dates of future meetings:

17.05.2022	9am
23.08.2022	9am
15.11.2022	9am
21.02.2023	9am

FORTH VALLEY NHS BOARD

TUESDAY 29 MARCH 2022

**9.2.5 Endowment Committee Minute – 21 January 2022
For Assurance**

Chair: Cllr Les Sharp, Non-Executive Board Member

Minute of the Forth Valley NHS Board Endowment Committee meeting held via Microsoft Teams 21 January 2022.

Participating: Cllr. Les Sharp, Non Executive Director, Forth Valley NHS Board, (Chair)
Mr. Scott Urquhart, Director of Finance, NHS Forth Valley.
Mr. Jonathan Procter, Director of Facilities and Infrastructure (Lead Director), NHS Forth Valley.
Mr. Robert Clark, Non Executive Director - Employee Director, Forth Valley NHS Board.
Mr. John Ford, Non Executive Director, Forth Valley NHS Board.
Mrs. Christine Crosbie, Finance Manager Endowments.
Mr Stephen Hall, Rathbones Investment Manager
Fiona Gillespie, Rathbones Head of Charities Scotland

1. APOLOGIES FOR ABSENCE

Mrs. Cathie Cowan, Chief Executive, NHS Forth Valley
Mr. Steven McAllister, Non Executive Director, Forth Valley NHS Board
Mr. Gordon Johnston, Non Executive Director, Forth Valley NHS Board
Mr. Mark Fairley, Senior Finance Manager
Mr. Craig Holden, Fundraising Manager

2. DECLARATIONS OF INTEREST

None

3. MINUTE OF THE FORTH VALLEY NHS BOARD ENDOWMENT COMMITTEE MEETING HELD ON FRIDAY 22nd OCTOBER 2021

The Committee approved the minute of the Forth Valley NHS Board Endowment Committee meeting.

4. INVESTMENT PERFORMANCE

Mr Stephen Hall highlighted some key pages from the main investment presentation “Item 4 – Forth Valley Health Board Endowment Fund”.

Mr Hall reminded the Committee that the investment portfolio is managed on a discretionary basis which means that the trustees set the rules in terms of investment objectives and risk. The objectives and risk level of the portfolio were recently reviewed by Rathbones and Christine Crosbie (Endowments Finance Manager) and reaffirmed the balanced position of the portfolio in terms of income and capital and placed the portfolio at risk level 5.

The current restrictions imposed on the portfolio include not investing in companies focussed on armaments, tobacco, alcohol and gambling.

Mr Hall outlined the current annual income projection and the detailed asset class breakdowns for the portfolio as at 31st December 2021.

Mr Hall then outlined the largest holdings within the investment portfolio and the overall portfolio performance.

The Committee were keen to understand the reference point for the target benchmark return. and Mr Hall gave a detailed explanation.

Mr Hall concluded his presentation with an update on the global macro economic growth outlook and confirmed that the spread of investments within the portfolio is tilted towards quality growth investments.

Following discussion, the committee thanked Mr Hall and noted the report.

5. MATTERS ARISING

- i) Clarification that Falkirk Community Hospital Unit 5 remained open
- ii) It was confirmed that the R&D grants documentation has been updated to state that replacement funding will not be considered, and to include the latest accommodation & subsistence rates for travel. It was also confirmed that from March 2022, the R&D Committee meetings will take place two weeks prior to the Endowment Committee meetings to facilitate the grants approval process.
- iii) A paper outlining Staff Benefit Proposals will be presented at the March 2022 Endowment Committee meeting.
- iv) A policy to manage the length of time monies remain unspent within funds will be presented at the October 2022 Endowment Committee Meeting.

6i) FINANCIAL GOVERNANCE REPORT

Mrs Crosbie provided a summary of the receipt/ (utilisation) of funds during the reporting period. It was confirmed that for the 9 months period to 31st December 2021, there was a net gain in funds of £314k mainly attributable to the unrealised increase (+£323k) in the market value of the investment portfolio. There was also a net utilisation (£60k) arising from charitable activities, and a realised gain of £52k on the disposal of investments. The cumulative Endowment Fund balances at 31st December 2021 were £3,553,546.

Mrs Crosbie reported on Unrestricted Funds. There was an under-utilisation of £20,497 for the nine months ending 31st December 2021. This is largely due to a £20k transfer from restricted funds, which was approved as a result of the slow moving and obsolete funds review. The other key drivers were outlined to the Committee. The Committee were asked to note that the most recent annual investment income projection (from Rathbones) is £5.6k lower than the annual budget. However, Rathbones are predicting further dividend declarations resulting in annual income of c£77k which would be c£2k below the annual budget.

Mrs Crosbie also reported on the Restricted Funds movement during the reporting period with a net utilisation of £56k, and a future net receipt of £210k in respect of the NHS Charities Together funding. The Stage 1 Urgent Response projects had spent a total of £79,112.

The Committee were asked to note that the Fundraising Manager (Mr Holden) was in the process of obtaining final reports on the Stage 1 projects and that this would be reported at the March Endowment Committee meeting.

Mrs Crosbie reported on designated funds. The total balance of designated funds as at the end of December 2021 was £285k. The majority of the balance relates to the D G Cochrane legacy (£203k) intended for Falkirk Royal Infirmary. See below agenda Item 11 for further details.

Mrs Crosbie updated the Committee on the performance of the Investment Portfolio (Appendix 5). It was highlighted that the value of the investment portfolio had increased by c£400k since the start of 2021/22, and the unrealised gain balance was £891k at the end of December 2021.

Mrs Crosbie concluded her report by reporting on the investment management performance (Appendix 6). In relation to this, Ms Crosbie highlighted to the Committee two graphs that had been introduced to track performance and fee levels. The Committee were asked to note that further work is going to be carried out to benchmark the fees against other health boards. This will be presented at a future endowment committee meeting.

In response to a request from the committee Mr Holden agreed to follow up with fund holders to ensure that there were plans to spend the Stage 1 monies in accordance with timescales.

The Committee approved the Financial Performance report for the 9 Months Ended 31st December 2021.

6ii) INVESTMENT MANAGER REPORTS

The Rathbones report for October to December 2021 was provided in the suite of papers distributed to the Committee and discussed at Item 4.

7. FUNDRAISING MANAGERS REPORT

In Mr Holden's absence, Mr Jonathan Procter outlined to the Committee the detailed progress on the various activities Mr Holden had been involved in since the last Committee meeting.

Mr Procter reported to the Committee that Mr Holden had attended a meeting last week with NHS Charities Together regarding the Stage 3 funding application and as part of this there were requests for additional information and justification regarding some of the projects proposed in the application.

The committee thanked Mr Procter for presenting Mr Holden's report.

8. COMMITTEE GOVERNANCE

I) National Review of Governance of NHS Endowment Funds

Mr Procter referred to recent correspondence from Scottish government which had been circulated to the committee and highlighted the main points from the National Review of Governance of NHS Endowment Funds.

More detailed national guidance is required before making any changes to the governance arrangements of the NHS Forth Valley Endowment Fund.

The Committee raised a number of concerns around personal liability insurance and increased costs of administration of the new arrangements which still had to be fully worked through.

The committee noted the update.

ii) Review of Endowment Committee's Terms of Reference, Objectives and Policies

In presenting the update Mr Procter referred to two changes that had been made to the governance documentation as follows:

- The expenditure policy has been updated to reflect the OSCR guidance which allows staff wellbeing expenditure in line with the recent COVID awards and
- The Research & Development Grants documentation had been added in Appendix 6.

The Committee approved the Terms of Reference, Objectives and Policies.

iii) Review of Endowment Fund's Risk Strategy

Mr Procter presented The Endowment Risk Strategy and advised that this has been mapped using the Health Board corporate risk template. There are 18 risks in total with the target of 12 risks being low and 6 medium classifications. There are no risks being noted in the high or very high category.

Following discussion, the Committee requested that the implications of the national review guidance should be added to the risk strategy and Ms Crosbie agreed to take this forward. The Committee approved the risk strategy.

9. ARTLINK SLA PROPOSAL

Mr Procter presented the SLA for consideration and reminded the Committee they had agreed to a minimum level of funding per year of £40k at the October Endowment Committee meeting.

Mr Holden had worked with colleagues to develop the SLA, and this was set out in the documentation for consideration.

Following discussion, the Committee approved the SLA proposal as presented.

10. INVESTING IN HEALTH LARGE GRANTS PROGRAMME 22/23

In Mr Holden's absence, Mr Procter updated the committee regarding a sum of c£23k which was discussed at the October Committee Meeting as being available to fund a large grants programme. A range of proposals are presented in the paper prepared by Mr Holden for the committee's consideration.

Following consideration, the following proposals were discounted by the Committee :

1. Neonatal proposal to update the website on the basis it should be covered by the Health Board budget.
2. Thrive Keep Well Programme bid for the Falkirk area, on the basis that the equivalent programme in Stirling & Clackmannanshire is funded by the Council.
3. Artlink as Committee have already committed £40k per year for the next 3 years as part of the Service Level Agreement.

The Committee requested more information on the Public Health Nutrition and the Livilands Resource Centre bids.

Mr Holden will come back to the March endowment committee meeting with detailed proposals for these two bids.

11. D G COCHRANE LEGACY PURPOSE

Ms Crosbie confirmed that this fund is an unrestricted designated fund. The history was outlined to the Committee. As the legacy was originally donated to the Falkirk Royal Infirmary endowment fund, it was recommended that the legacy be approved for utilisation at Falkirk Community Hospital.

The Committee approved the use of the D G Cochrane legacy (c£203k) for utilisation at Falkirk Community Hospital.

12. BURSARY COMMITTEE MEETING MINUTES

The committee noted the minutes of the Bursary committee.

13. ANY OTHER COMPETENT BUSINESS

Mr Robert Clark enquired with regard to increasing the bursary funding from the current year award of £9,000. Mrs Christine Crosbie confirmed that a proposal should be submitted to be considered as part of the budget process.

14. DATE OF NEXT MEETING

The date of the next meeting of the Forth Valley NHS Board Endowment Committee is scheduled for Friday 25th March 2022. The meeting will take place on Microsoft Teams.

FORTH VALLEY NHS BOARD
TUESDAY 29 MARCH 2022

9.2.6 Area Clinical Forum Minute – 20 January 2022
For Assurance

Chair: Mrs Kirstin Cassels, Non-Executive Board Member

Minute of the **Area Clinical Forum** meeting held on **Thursday 20 January 2022 at 6.15pm** via MS Teams.

Present: Kirstin McIntosh (Chair) Claire Neil James King
Rhona McNab Alison McMullan Elizabeth Kilgour

In Attendance: Angela Wallace, Director of Nursing (for Item 2 only)
Sarah Smith, Corporate Services, (*Minute Taker*)

Item 2 was taken at this point in the Agenda

2. Action Plan from ED Report, with linkage to Whistleblowing

The ACF received a Presentation from Angela Wallace, Director of Nursing, in relation to the ED Report as well as Whistleblowing and the Speak Up Initiative.

The Presentation covered the following areas:

- Background and Review Process
- Key Themes identified by staff
- Additional Actions
- ED Improvement Plan – progress
- Looking to the Future
- Our ongoing commitment
- Listening, Learning and Improving Culture
- Speak Up Initiative
- Whistleblowing Standards

Following the Presentation, the Committee noted the need for those leading on the work to also be supported. Professor Wallace confirmed the deeply personal impact from the issues raised.

During a discussion on Whistleblowing, it was noted that there had only been 4 concerns raised since April 2021. The potential for Ambassadors to be invited to a future ACF meeting was proposed in order for them to share experiences and allow members to feed back to their Professional Groups.

Professor Wallace then left the meeting.

1. Welcome and apologies

The Chair welcomed everyone to the meeting. Apologies were noted on behalf of Andrew Murray and Fiona McPhail.

3. Minutes of Area Clinical Forum 18 November 2021

The note of the meeting held on 18 November 2021 was approved as an accurate record.

4. Minutes of Reporting Groups/Feedback from Chairs

It was noted that admin support was now in place for the Psychology Advisory Committee as well as the Area Pharmaceutical Committee.

4.1 Allied Health Professionals

The Chair of the Committee, Glenn Carter, had now left NHS Forth Valley. It was agreed that contact would be made with the Associate Director of AHP's Pauline Beirne, to ascertain future plans for the Committee.

Action: Admin

4.2 Area Medical Committee

The Chair of the AMC, James King, confirmed the Committee remained in abeyance. It was noted that the GP Sub Committee had continued to meet regularly with good attendance. It was requested the Chair of the GPSC, David Herron be invited to attend the ACF. This was approved by the Committee.

Action: Admin

4.3 Area Nursing & Midwifery Committee

It was noted that this Committee had also not met for some time. It was agreed that follow up would be undertaken to ascertain the current position.

Action: Admin

4.4 Area Optical Committee – 25 October 2021

The Chair of the AOC, Rhona King, noted there had been no meeting since the last ACF. The minute of the meeting held on 25 October 2021 had been circulated for information.

4.5 Area Pharmaceutical Committee – 9 December 2021

The Chair of the APC, Kirstin Cassells, provided feedback from the last meeting. The main topic of discussion had been around Covid Vaccine and the Omicron variant that was starting to be reported. Concerns had been highlighted around potential slippage of PPE and Cleaning rotas over the Festive period. Vaccines were also discussed.

The Whole System Working Project was discussed, which was taking place within Primary Care. The aim was to reduce acute requests within GP Practices and increase serial prescribing.

A Pharmacy Application was also discussed by the Committee and would be presented to a future PPC.

Note was made of admin support now being in place.

It was also reported that the Director of Pharmacy had resigned. The two Associate Directors of Pharmacy were currently providing interim cover. The DoP had always been an active member of the Area Pharmacy Committee, which it was hoped would continue.

4.6 Psychology Advisory Committee 10 November 2021

An update on the PAC was provided by Alison McMullan. It was confirmed that meetings were now being aligned with the Area Clinical Forum.

A meeting had taken place in January 2022, which was Chaired by Clare Neil. Focus was on ensuring reps from different areas of the service. Child and Adolescent Mental Health was noted as an outstanding area.

There had been discussion at the meeting on recruitment and retention and what would make staff stay in Forth Valley, as well as making them move on. Consistent information was provided across the services. This has been fed back to the Management Groups with an intention to amend job descriptions to try and encourage recruitment of psychologists. A national shortage was noted.

Challenge had also been identified around management structures in both Psychology and Mental Health. Changes in roles and job titles were noted.

James King had noted a similar position with a lot of staff not being aware they also reported to Health and Social Care Partnerships, as well as the Health Board.

Alison McMullan highlighted discussion around a potential National Advert for Psychology.

Kirstin noted the challenge around recruitment and agreed this would be followed up with Chief Executive, Cathie Cowan.

Action: ACF Chair

4.7 Area Dental Committee

There was no representative present from the Committee. It was also noted there had been no meeting held since the last Area Clinical Forum.

Health Care Science Leads (not on Agenda)

A Flash Report was presented by Liz Kilgour and this would be circulated to ACF members.

It was noted that local meetings had been stood down on the Acute site, but National meetings had picked up with Leads from each Board attending.

Detail was provided around posts seconded into Scottish Government. One was looking at education and training pathways and another looking at Workforce.

Lothian Paediatric Ideology Review had now been published. Areas of focus had included questions around regulation of Healthcare Science Professionals. This had highlighted people who have missed registration dates due to movement to O365 and change in email addresses. A drive had been undertaken with Healthcare Scientists within NHS Forth Valley to request checking of registration.

From the Lab Executive Board, note was made of the Cellular Pathology Review which was now at point of having target operating model produced by 31/03/22. This would determine what pathology services would look like across the country.

Clinical Physiology focus was on workforce planning and recruitment. This was following the announcement that GCU would no longer be running the Clinical Physiology Undergraduate Degree. Work would be required around training routes.

Healthcare Science Week would take place 11-20 March 2022.

Nationally a Short Life Working Group was in place to look at a national job description for a Director of Healthcare Science. Job matching was currently underway within Grampian Agenda for Change Teams.

5. AOCB

There was no other competent business raised.

6. Future Agenda Items

It was noted that Workforce Planning would be brought to the next meeting. This would be led by Linda Donaldson, Director of Human Resources.

It was also agreed that Vice Chair for ACF would be added to the next Agenda with a request for Committee members to give this consideration.

The next meeting would take place via MS Teams, but it was agreed future plans would be discussed at the next meeting.

7. Date of next meeting

The next meeting of the Area Clinical Forum will be held on Thursday 24 March 2022 at 6.15 pm via Ms Teams.

The meeting was closed at 7.32 pm.