

NHS Greater Glasgow and Clyde

NHS Board Meeting

17 April, 2007

Board Paper No. 07/13

Head of Board Administration

NHS Greater Glasgow and Clyde – Annual Review of Governance Arrangements

Recommendation

The NHS Board is asked to:

- i) approve the revised Standing Orders for the Proceedings and Business of the NHS Board and the Decisions Reserved for the NHS Board (Appendix 1);
- ii) approve the revised Standing Financial Instructions (Appendix 2) and the Fraud Policy (Appendix 3);
- iii) approve the revised Risk Management Strategy (Appendix 4);
- iv) note the intention to produce a single Code of Conduct for staff that incorporates the Standards of Business Conduct and Freedom of Expression Policy;
- v) approve the remits of the following Standing Committees – Audit Committee, Clinical Governance Committee, Staff Governance Committee, Performance Review Group, Research Ethics Governance Committee, Public Involvement Committee, Area Clinical Forum, and Pharmacy Practices Committee;
- vi) note that the memberships of the Standing and CH(C)P Committees will be re-considered once notification is received of any changes in nominated members notified by Local Authorities following the local elections and that a paper on revised Committee memberships which also take account of the impact of recent changes to the Non-Executive Director cohort will be submitted to the June 2007 NHS Board meeting for approval;
- vii) approve the Standing Orders, remit and membership of the new Mental Health Partnership Committee;
- viii) in line with (i) above, note that the Chairman will seek nominations from Non-Executive Members for the position of Vice Chair of the NHS Board for a 4-year term and thereafter seek the Board's approval to the appointment of Vice Chair at the June 2007 meeting.

A. Introduction

In February 2005 the NHS Board approved the new organisational arrangements to implement the White Paper – 'Partnership for Care'. Subsequently two reviews of the governance arrangements for the moves to single system working were carried out and, as a result, the NHS Board approved in December 2005 a detailed set of new governance arrangements to support the new organisation.

The new arrangements have settled down and are viewed as providing a solid governance framework for the NHS Board to properly discharge its responsibilities and statutory functions.

B. Governance Documentation

- Standing Orders for the Proceedings and Business of the NHS Board

Attached as Appendix 1 are the revised Standing Orders for the Proceedings and Business of the NHS Board – in addition to adding ‘Clyde’ to the name of the organisation, one change has been to Standing Order 4.1. This has been made as a result of comments made at the NHS Board last year on the desire to move the appointment term of Vice Chair from annual to a 4-year term.

Under the Ethical Standards in Public Life etc. Act 2000, the Register of Interests for NHS Board Members has recently been updated and made publicly available. Further updates will take place as a result of the recent appointments to the NHS Board. The annual training for NHS Board Members was undertaken as usual at the December NHS Board Seminar.

- Decisions Reserved for the NHS Board

No changes proposed.

- Standing Financial Instructions

The Board approved, at its October 2006 meeting, the new Standing Financial Instructions (SFIs) to reflect the new single system organisation and integration with Clyde. As part of this current review of governance arrangements it is proposed to make a number of minor amendments to the Standing Financial Instructions to reflect operational or internal control needs. These are as follows:

- Section 9 – Non-Pay Expenditure: amended to add clarification around Standards of Business Conduct (page 21).
- Section 10 – Orders, Quotations and Tenders: amended to add further controls to ensure competition and value for money, particularly around the Waiver to Tender process (pages 27 and 28).
- Section 18 – Fraud, Losses and Legal Claims: amended to reflect that a Fraud Policy has been developed (page 49).
- Section 19 - Patients' Private Funds and Property: the paragraph relating to funeral expenses has been deleted to reflect current legislation (page 53).

A copy of the revised SFI's is attached (Appendix 2), with the added paragraphs highlighted.

The Board also approved at its April 2006 meeting the Schedule of Authorised Signatories for health care agreements and related contracts and also those authorised to sign on behalf of Scottish Ministers in relation to property transactions. No further changes are proposed to this schedule at this stage.

- Fraud Policy

Previously separate fraud policies or action plans were in place for each of the former divisions of NHS Greater Glasgow and for the former NHS Argyll and Clyde. An overarching Fraud Policy is required for NHS Greater Glasgow and Clyde to ensure consistent arrangements for the prevention and detection of fraud. A draft Fraud Policy for NHS Greater Glasgow and Clyde is therefore presented for approval at Appendix 3. This draft Policy has been considered and approved by the Audit Committee and by the Area Partnership Forum.

This Policy will be supported by a Fraud Action Plan with guidance to both staff and managers. These documents will be harmonised with the proposed Single Code of Conduct.

- Risk Management Strategy

The draft Risk Management Strategy at Appendix 4 was approved by the Risk Management Steering Group and subsequently endorsed by the Audit Committee in March 2007 for submission to the NHS Board for approval. It is based on the Strategy approved by the NHS Board in March 2005 and has been updated to reflect the revised reporting structures and responsibilities following organisational change.

- Standards of Business Conduct

NHS Board Members continue to adhere to the NHS Code of Conduct and there is a requirement for staff to adhere to the Standards of Business Conduct.

The Planning, Policy and Performance Group recently considered the issue of conduct for members of staff and agreed that a single Code of Conduct should be developed. This will take account of extant national guidance on the Standards of Business Conduct, detailed NHSGG&C guidance supporting the Standards of Business Conduct and also the Freedom of Expression Policy. These will be incorporated into a single Code and issued to staff. It is intended that the work to bring together these matters into a single Code will be completed shortly and then distributed to staff in order that they are clear on the Standards of Conduct expected within NHSGG&C.

C Standing Committees of NHS Board

The single system for the Standing Committees has been effective from 1 January 2006 and ahead of the Annual Review of the Governance Arrangements for the NHS Board each Standing Committee was asked to review its remit and provide any update/alterations as a result of the first year of working with the new arrangements. In addition, most of the Standing Committees updated/revised their remit during 2006/07 to take account of the inclusion of 'Clyde'.

- i) Audit (Appendix 5)

The Audit Committee has recommended two specific changes to its remit – a move from a minimum of 6 meetings per annum to a minimum of 4 meetings per annum with the provision for additional meetings as required. The intention is to allow more flexibility with the number of meetings being dictated by the workload. During the course of the last financial year 5 meetings were sufficient to allow the Committee to discharge its responsibilities. In terms of good practice, the NHS Scotland Audit Handbook recommends that Audit Committees should meet not less than 3 times a year.

The second change is in respect of property transaction monitoring – this is to allow the Audit Committee, on the NHS Board's behalf, to receive and approve the Internal Auditors Report on the Review of Property Transaction Monitoring and report the results of the review, on behalf of the NHS Board, to the Scottish Executive in accordance with the NHS Scotland Property Transaction Handbook.

This proposed change was to consolidate and streamline existing practice by formally delegating responsibility to the Audit Committee for receiving the Internal Auditors Report and reporting onwards to the Scottish Executive.

The Audit Committee remit is attached as Appendix 2 and it is recommended the NHS Board approves this revised remit.

ii) Clinical Governance (Appendix 6)

The remit for the Clinical Governance Committee is attached as Appendix 6. It was subject to revision in June 2006 and the NHS Board is therefore asked to approve the remit of the Clinical Governance Committee.

iii) Staff Governance (Appendix 7)

The remit for the Staff Governance Committee is attached as Appendix 7. It was subject to revision in June 2006 and the NHS Board is therefore asked to approve the revised remit of the Staff Governance Committee.

iv) Performance Review Group (Appendix 8)

The remit for the Performance Review Group is attached as Appendix 8. It was subject to revision in March 2006 and the NHS Board is therefore asked to approve the revised remit of the Performance Review Group.

v) Public Involvement Committee (Appendix 9)

The remit for the Public Involvement Committee is attached as Appendix 9. It was subject to revision in April 2006 and the NHS Board is therefore asked to approve the revised remit of the Public Involvement Committee.

vi) Research Ethics Governance Committee (Appendix 10)

The remit for the Research Ethics Governance Committee is attached as Appendix 10. It was subject to revision in January 2007 and the NHS Board is therefore asked to approve the revised remit of the Research Ethics Governance Committee.

vii) Pharmacy Practices Committee (Appendix 11)

The remit for the Pharmacy Practices Committee is attached as Appendix 11. It was subject to updating in April 2007 and the NHS Board is therefore asked to approve the revised remit of the Pharmacy Practices Committee.

viii) Area Clinical Forum (Appendix 12)

The remit for the Area Clinical Forum is attached as Appendix 12. It was subject to revision in April 2006 and the NHS Board is therefore asked to approve the remit of the Area Clinical Forum.

ix) The Mental Health Partnership (Appendix 13)

With the establishment of the Mental Health Partnership, work has been under way to develop Standing Orders, remit and a constitution for the membership of the Mental Health Partnership Committee, with the intention that its first meeting would be held at the end of June 2007.

The NHS Board is asked to approve the Standing Orders, remit, constitution and membership for the Mental Health Partnership Committee.

x) Community Health (Care) Partnerships

No changes to the remit and responsibilities of the Community, Health and Care Partnerships or Community Health Partnerships are proposed at this stage although clearly there will be changes to the membership of these committees as the result of the forthcoming local elections. It is the intention that a paper be submitted to the June NHS Board meeting, making recommendations updating the membership of all the NHS Board's Standing Committees, including the Community Health (Care) Partnership Committees.

xi) Committee Membership

As members will be aware, there has been a recent change to the NHS Board membership and also there may be changes in the nominations from Local Authorities for Councillors to be nominated to sit on the NHS Board as Non-Executive Directors, as a result of the forthcoming local elections. On that basis, members are asked to note that the membership of all Standing committees, including the CH(C)Ps will be re-considered once notification is received of any changes in nominated members notified by Local Authorities following the election. Thereafter a paper will be submitted to the June NHS Board meeting seeking approval to revised memberships to the Board's Standing Committees.

D Appointment of Vice Chair

It is intended that the Chairman will seek nominations to the position of Vice Chair in the next 6 weeks and thereafter seek the NHS Board's approval at the June 2007 meeting to the appointment of a Vice Chair for a 4-year term (if the revised period of appointment is approved by the NHS Board).

Conclusion

The NHS Board is asked to give consideration to the recommendations on Page 1 of this report and agree to receive a follow-up paper on the membership of its Standing Committees and election of a Vice-Chair at the June 2007 meeting.

John C Hamilton
Head of Board Administration
April 2007
0141-201-4608

NHS GREATER GLASGOW AND CLYDE

**STANDING ORDERS FOR THE PROCEEDINGS
AND BUSINESS OF NHS GREATER GLASGOW AND CLYDE**

1. General

- (1) These Standing Orders for regulation of the conduct and proceedings of NHS Greater Glasgow and Clyde (the common name for Greater Glasgow Health Board) and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 and subsequent Statutory Instruments [the Regulations]. Members of the Board are expected to subscribe to comply with:-

- (a) the Code of Conduct;
- (b) the Code of Accountability; and
- (c) the Code of Practice on Openness issued by the Scottish Executive; and
- (d) the NHS Greater Glasgow Code of Conduct made under the Ethical Standards in Public Life etc (Scotland) Act 2000,

all of which shall be regarded as if incorporated into these Standing Orders.

- (2) Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.
- (3) Any one or more of the Board's Standing Orders may be suspended on a duly seconded motion, incorporating the reasons for suspension, if carried by a majority of Members present.
- (4) Any one or more of the Board's Standing Orders may be varied or revoked at a meeting of the Board by a majority of Members present and voting, provided the agenda for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment.
- (5) In these Standing Orders, references to the male gender shall apply equally to the female gender.
- (6) The Head of Board Administration shall provide a copy of these Standing Orders to all Members of the Board on appointment and to senior managers.

2. Membership

The membership of the Board shall be those persons appointed by the Scottish Ministers and comprise the Chairperson, Non-Executive and Executive Directors, as determined by the Regulations.

3. Chairperson

- (1) At every meeting of the Board if the Chairperson is absent from any meeting the Vice-Chairperson, if present, shall preside. If both the Chairperson and Vice Chairperson are absent, a Non-Executive Director chosen at the meeting shall preside.

- (2) The duty of the person presiding at a meeting of the Board or its Committees is to ensure that the Standing Orders 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.
- (3) The Chairperson may resign office at any time on giving notice to the Scottish Ministers and shall hold office in accordance with appointment by Scottish Ministers unless he/she is disqualified.

4. Vice-Chairperson

- (1) The Board shall appoint a Non-Executive Director to be Vice-Chairperson and the person appointed shall, so long as he/she remains a Member of the Board, continue in office for a 4-year term.
- (2) The Member appointed as Vice Chairperson may at any time resign from the office of Vice-Chairperson by giving notice in writing to the Chairperson and the Members may appoint another Non-Executive Director as Vice-Chairperson in accordance with Standing Order 4(1).
- (3) Where the Chairperson has died, ceased to hold office, or is unable to perform his/her duties due to illness, absence from Scotland or for any other reason, the Vice-Chairperson shall assume the role of the Chairperson in the conduct of the business of the Board and references to the Chairperson shall, so long as there is no Chairperson able to perform the duties, be taken to include references to the Vice-Chairperson.

5. Resignation and Removal of Members

- (1) A Member may resign office at any time during the period of appointment by giving notice in writing to the Scottish Ministers to this effect.
- (2) If the Scottish Ministers consider that it is not in the interests of the health service that a Member of a Board should continue to hold that office they may forthwith terminate that person's appointment.
- (3) If a Member has not attended any meeting of the Board, or of any Committee of which they are a Member, for a period of six consecutive months, the Scottish Ministers shall forthwith terminate that person's appointment unless satisfied that -
 - (a) the absence was due to illness or other reasonable cause; and
 - (b) the Member will be able to attend meetings within such period as the Scottish Ministers consider reasonable.
- (4) Where a Member who was appointed for the purposes of paragraph 2A of Schedule 1 to the NHS (Scotland) Act 1978 (representative of University) ceases to hold the post in a university with a medical or dental school, which was held at the time of appointment for those purposes, the Scottish Ministers may terminate the appointment of that person as a Member.

- (5) Where any Member becomes disqualified in terms of Regulation 6 of the Regulations that Member shall forthwith cease to be a Member.

6. Ordinary Meetings

- (1) The Board shall meet at least 6 times in the year and meetings of the Board, unless otherwise determined in relation to any particular meeting, shall be held in the offices of the Board at a date and time determined by the Board or the Chairperson and specified in the notice calling the meeting.
- (2) Subject to Standing Order 7 below, the Chairperson (or Executive Director of the Board who may sign on the Chairperson's behalf) shall convene meetings of the Board by issuing to each Member, not less than five clear days before the meeting, a notice detailing the place, time and business to be transacted at the meeting, together with copies of all relevant papers (where available at the time of issue of the agenda).
- (3) Meetings of a Board may be conducted in any other way in which each member is enabled to participate although not present with others in such a place.
- (4) A meeting shall be conducted by virtue of the above only on the direction of the Chairperson/Vice-Chairperson of the Board.
- (5) The notice shall be delivered to every Member or sent by post to the place of residence of members, or such other address as notified by them to the Head of Board Administration.
- (6) Lack of service of the notice on any Member shall not affect the validity of a meeting.
- (7) Notice of Board meetings shall be given by the person convening the meeting in accordance with the provisions of the Public Bodies (Admission to Meetings) Act 1960.

7. Decisions Reserved for the Board and Scheme of Delegation

- (1) The matters set out in the Annex to these Standing Orders are matters, which may only be determined at a meeting of the Board. All other matters are delegated in accordance with the Scheme of Delegation or remitted to a Standing Committee of the NHS Board.
- (2) Notwithstanding (1) the Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself.

8. Requisitioned (Special) Meetings

- (1) The Chairperson of the Board may call a meeting of the Board at any time and shall do so on receipt of a requisition in writing for that purpose which specifies the business to be transacted at the meeting and is signed by one third of the whole number of Members of the Board.

- (2) In the case of a requisitioned meeting, the meeting shall be held within 14 days of receipt of the requisition and no business shall be transacted at the meeting other than that specified in the requisition.
- (3) If the Chairperson refuses to call a meeting of the Board after a requisition for that purpose, or if, without so refusing, does not call a meeting within 7 days after such a requisition has been presented, those Members who presented the requisition may forthwith call a meeting by signing the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

9. Conduct of Meetings

- (1) No business shall be transacted at a meeting of the Board unless there are present, and entitled to vote, at least one third of the whole number of Members, of whom at least two are Non-Executive Directors.
- (2) No business shall be transacted at any meeting of the Board other than that specified in the agenda except on grounds of urgency and with the consent of the majority of the Members of the Board present. Any request for the consideration of an additional item of business shall be raised at the start of the meeting and the consent of the majority of Members for the inclusion must be obtained at that time.
- (3) All acts of, and all questions coming and arising before, the Board shall be done and decided by a majority of the Members of the Board present and voting at a meeting of the Board. Majority agreement may be reached by consensus without a formal vote. Where there is doubt, a formal vote shall be taken by Members by a show of hands, or by ballot, or any other method determined by the person presiding at the meeting.
- (4) In the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote.
- (5) Where a post of Executive Director is shared by more than one person:
 - (a) Those persons, or any one of them, shall be entitled to attend any meeting of the Board
 - (b) Where more than one of those persons attend they shall be entitled to a collective vote on any single topic raised at the meeting provided they have agreed between themselves as to the way in which the vote is to be cast
 - (c) If they do not so agree, no vote shall be cast by them
 - (d) The presence of any one or more of those persons shall count as the presence of one person for the purpose of the quorum

- (6) A motion which contradicts a previous decision of the Board shall not be competent within six months of the date of such decision, unless submitted in the minutes of a Committee, or notice of the proposed variation is provided in the notice of the Board meeting. Where a decision is rescinded, it shall not affect or prejudice any action, proceeding or liability which may have been competently done or undertaken before such decision was rescinded.

10. Minutes

- (1) The names of Members and other persons present at a meeting of the Board, or of a Committee of the Board, shall be recorded in the minutes of the meeting.
- (2) Minutes of the proceedings of meetings of the Board and its Committees and decisions thereof shall be drawn up by the Head of Board Administration (or his/her authorised nominee) and be submitted to the next ensuing meeting of the Board or relevant Committee for approval as to their accuracy and signed by the person presiding at that next meeting.

11. Order of Debate

- (1) Any motion or amendment shall, if required by the Chairperson, be reduced to writing, and after being seconded, shall not be withdrawn without the leave of the Board. No motion or amendment shall be spoken upon, except by the mover, until it has been seconded.
- (2) After debate, the mover of any original motion shall have the right to reply. In replying he/she shall not introduce any new matter, but shall confine himself/herself strictly to answering previous observations, and, immediately after his/her reply, the question shall be put by the Chairperson without further debate.
- (3) Any Member in seconding a motion or an amendment may reserve his/her speech for a later period of the debate.
- (4) When more than one amendment is proposed, the Chairperson of the meeting shall decide the order in which amendments are put to the vote. All amendments carried shall be incorporated in the original motion which shall be put to the meeting as a substantive motion.
- (5) A motion to adjourn any debate on any question or for the closure of a debate shall be moved and seconded and put to the meeting without discussion. Unless otherwise specified in the motion, an adjournment of any debate shall be to the next meeting.

12. Adjournment of Meetings

A meeting of the Board, or of a Committee of the Board, may be adjourned by a motion, which shall be moved and seconded and be put to the meeting without discussion. If such a motion is carried, the meeting shall be adjourned until the next scheduled meeting or to such day, time and place as may be specified in the motion.

13. Declaration of Interests and Register of Interests

- (1) Members of the NHS Board shall observe all their obligations under the Code of Conduct for Members of the NHS Greater Glasgow and Clyde made under the Ethical Standards in Public Life etc. (Scotland) Act 2000.
- (2) In case of doubt as to whether any interest or matter should be the subject of a notice or declaration under the Code, Members should err on the side of caution and submit a notice/make a declaration or seek guidance from the Standards Commission, the Chairperson or Head of Board Administration as to whether a notice/declaration should be made.
- (3) Where the Code requires an interest to be registered, or an amendment to be made to an existing interest, this shall be notified to the Head of Board Administration in writing by giving notice in writing using the standard form available from the Head of Board Administration within one month of the interest or change arising. The Head of Board Administration will write to Members every six months to request them to formally review their declaration.
- (4) Persons appointed to the NHS Board as Members shall have one month to give notice of any registerable interests under the Code, or to make a declaration that they have no registerable interest in each relevant category as specified in the standard form to be supplied by the Head of Board Administration.
- (5) The Head of Board Administration will be responsible for maintaining the Register of Interests and for ensuring it is available for public inspection at the principal offices of the NHS Board at all reasonable times and will be included on the NHS Board's web site.
- (6) The Register shall include information on:
 - (i) the date of receipt of every notice;
 - (ii) the name of the person who gave the notice which forms the entry in the Register; and
 - (iii) a statement of the information contained in the notice, or a copy of, that notice.
- (7) Members shall make a declaration of any gifts or hospitality received in their capacity as a Member of the NHS Board. Such declarations shall be made to the Head of Board Administration who shall make them available for public inspection at all reasonable times at the Principal Offices of the NHS Board and on the NHS Board's web site (www.nhsgg.org.uk).
- (8) The Head of Board Administration (or authorised nominee) shall maintain Registers under the provisions of NHS Circular HDL(2003)62 covering:

- (i) Joint working arrangements between employees and independent Family Health Service Contractors and the pharmaceutical industry; and
- (ii) Financial interests held by employees and independent Family Health Service contractors with any organisations which may impact upon any funding arrangements made between the Board and any non-NHS organisations.

The Register shall be made publicly available during normal office hours at the Principal offices of the Board.

14. Suspension of Members

Any Member who disregards the authority of the Chairperson, obstructs the meeting, or conducts himself/herself offensively shall be suspended for the remainder of the meeting, if a motion (which shall be determined without discussion) for his/her suspension is carried. Any person so suspended shall leave the meeting immediately and shall not return without the consent of the meeting. If a person so suspended refuses, when required by the Chairperson, to leave the meeting, he/she may immediately be removed from the meeting by any person authorised by the Chairperson so to do.

15. Admission of Public and Press

- (1) Members of the public and representatives of the press shall be notified of meetings and shall be admitted to meetings of the Board in accordance with the provision of the Public Bodies (Admission to Meetings) Act 1960.
- (2) Members of the public and representatives of the press admitted to meetings of the Board may be excluded from any meeting by decision of the Board, where, in the opinion of the majority of Members present, publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, or such other special reason as may be specified in the decision.
- (3) Representatives of the press and members of the public admitted to meetings shall require the authority of the Board for each occasion they may wish to record the proceedings of the meeting other than by written notes.
- (4) Members of the public may, at the Chairperson's sole discretion, be permitted to address the Board or respond to questions from Members of the Board, but shall not generally have a right to participate in the debate at Board Meetings.
- (5) Nothing in this Standing Order shall preclude the Chairperson from requiring the removal from a meeting of any person or persons who persistently disrupts the proceedings of a meeting.

16. Execution of Documents

- (1) Any document or proceeding requiring authentication by the Board shall be subscribed by one Member of the Board, the Head of Board Administration (or his/her authorised nominee) and the Director of Finance (or his/her authorised nominee).

- (2) The Director of Finance shall be responsible for maintaining a record of officers authorised to sign documents on behalf of the Board in accordance with provisions contained within Standing Financial Instructions.
- (3) Where a document requires for the purpose of any enactment or rule of law relating to the authentication of documents under the Law of Scotland, or otherwise requires to be authenticated on behalf of the Board it shall be signed by an Executive Director of the NHS Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the provisions of 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.
- (4) Scottish Ministers shall direct on which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.
- (5) 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.

17. Committees

- (1) Subject to any direction issued by Scottish Ministers, the Board shall appoint such Committees and Sub-Committees as it thinks fit. The remits of the NHS Board and Committees their quora and reporting arrangements shall be reviewed annually by the Board.
- (2) Subject to any direction or regulation issued by Scottish Ministers, Committees of the Board may co-opt persons as Members of Board Committees and Sub-Committees, as and when required.
- (3) The Chairperson of a Committee may call a meeting of that Committee any time and shall call a meeting when requested to do so by the Board.
- (4) The foregoing Standing Orders, so far as applicable, and so far as not hereby modified, shall be the rules and regulations for the proceedings of formally constituted Committees and Sub-Committees, subject always to the following additional provisions:
 - (a) The Chairperson and Vice-Chairperson of the Board and the Chief Executive of the Board shall have the right to attend all Committees except where the constitution of such Committees precludes such an arrangement.
 - (b) Meetings of Committees and Sub-Committees shall not be open to the public and press unless the Board decides otherwise in respect to a particular Committee or a particular meeting of a Committee.

- (c) Committees of the Board and the Convenors thereof shall be appointed annually at the meeting of the Board in April or at a meeting to be held as soon as convenient thereafter. Casual vacancies in the membership of Committees thereof shall be filled, so far as practicable, by the Board at the next scheduled meeting following a vacancy occurring.
- (d) Committees of the Board may appoint Sub-Committees and Convenors thereof as may be considered necessary.
- (e) Minutes of the proceedings of Committees shall be drawn up by the Head of Administration (or his/her authorised nominee) and submitted to the Board at the first scheduled meeting held not less than seven days after the meeting of the Committee for the purpose of advising the Board of decisions taken.
- (f) Minutes of meetings of Sub-Committees shall be submitted to their parent Committee at the first scheduled meeting of the parent Committee held not less than seven days after the meeting of the Sub-Committee for the purpose of advising the Committee of decisions taken.
- (g) A Committee, or Sub-Committee may, notwithstanding that a matter is delegated to it, direct that a decision shall be submitted by way of recommendation to the Board or parent Committee for approval.

December 2005
Revised April 2007

NHS Greater Glasgow and Clyde

Standing Financial Instructions

*Approved
Revision*

*October 2006
April 2007*

NHS Greater Glasgow & Clyde Standing Financial Instructions

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Appendix

1 Standards of Business Conduct

NHS Greater Glasgow & Clyde Standing Financial Instructions

SECTION 1

INTRODUCTION AND STANDARDS OF BUSINESS CONDUCT

GENERAL

- 1.1 These Standing Financial Instructions (SFI's or Instructions) detail the financial responsibilities, policies and procedures to be adopted by NHS Greater Glasgow and Clyde (NHSGGC). They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.
- 1.2 These Instructions are issued in accordance with the National Health Service (Financial Provisions) (Scotland) Regulations 1974, Regulation 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 the Board, its members and officers, in relation to financial matters. They will have effect as if incorporated in the Standing Orders for the Proceedings and Business of the Board.
- 1.3 The SFI's identify the financial responsibilities that apply to everyone working for NHSGGC and its constituent organisations. They do not provide detailed procedural advice. However, financial procedural notes will be prepared to reflect the requirement of these SFI's. These statements should therefore be read in conjunction with relevant these financial procedural notes. Financial procedures, and changes thereto, will be approved by the appropriate Audit Support Group.
- 1.4 Departmental heads with financial responsibilities will fulfil these responsibilities in a way that complies with the requirements of these Instructions, and will put in place, and maintain procedures that comply with the SFI's.
- 1.5 The SFI's are in themselves a component of wider Risk Management Strategy that seeks to safeguard all of the processes of NHSGGC.
- 1.6 Failure to comply with SFI's is a disciplinary matter which could result in dismissal.

STANDARDS OF BUSINESS CONDUCT

- 1.7.1 The Code of Conduct and the Code of Accountability are issued to all NHSGGC Board Members on appointment, and a condition of their appointment is acceptance of, and compliance with, the terms of these Codes and the Code of Practice on Openness. These SFI's are intended to support all staff in complying with the Standards of Business Conduct for NHS Staff issued by the NHS Scotland Management Executive (The Standards).
- 1.7.2 The Standards offer guidance to NHS employers and staff in maintaining strict ethical standards in the conduct of NHS business. The Standards are incorporated into the contracts of employment of all Board staff and failure to comply with them could result in disciplinary action. The Standards are reproduced in full at Appendix 1 but the key principles are that:
 1. public sector bodies, including the NHS, must be impartial and honest in the conduct of their business and their employees should remain above suspicion.
 2. staff should be impartial and honest in the conduct of all their official business.

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3. staff should not place themselves under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence them in the performance of their duties.
4. staff must declare any private interest relating to their official duties.
5. it is the responsibility of all staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.
6. staff should not seek to advantage or further their private business or other interests in the course of their official duties.
7. staff are expected to use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

1.7.3 Further information is given at Appendix 1 on the following matters :

1. the implications of the Prevention of Corruption Acts 1906 and 1916
2. declaration of interests
3. acceptance of gifts and hospitality
4. preferential treatment in private transactions
5. commercial sponsorship.

1.7.4 If staff have any questions on the interpretation or application of the Standards, they should contact their line manager or the Financial Governance and Audit Manager.

TERMINOLOGY

- 1.8 Any expression to which a meaning is given in the Health Service Acts or in the financial regulations made under the Acts shall have the same meaning in these Instructions; and
1. "NHS Greater Glasgow and Clyde" (NHSGGC) is the common name used to define the entity/organisation whose legal name is Greater Glasgow Health Board.
 2. "Board" means the Management Committee of NHSGGC/Greater Glasgow Health Board, or such other Committee of the Board to which powers have been delegated.
 3. "Budget" means an allocation of resources by the Board, Chief Executive or other officer with delegated authority expressed in financial terms, for the purposes of carrying out, over a specific period, a function or group of functions of the NHSGGC Board.
 4. "Chief Officer" means any officer who is directly accountable to the Chief Executive i.e. Directors, Chief Operating Officers/Directors of Divisions/Partnerships and some Heads of Department.
 5. "Budget Holder" means the Chief Officer or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
 6. "SEHD" means Scottish Executive Health Department

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7. "Director of Finance" means Director of Finance – Corporate and Partnerships, unless otherwise stated, or senior staff with delegated authority.

RESPONSIBILITIES AND DELEGATION

- 1.9 The Board will exercise financial supervision and control by:-
 1. formulating the financial strategy;
 2. requiring the submission and approval of annual budgets within approved allocations;
 3. approving SFI's;
 4. defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation.
- 1.10 All directors and employees have a general responsibility for the security of the property of NHSGGC, for avoiding loss, for economy and efficiency in the use of resources and for conforming with the requirements of these Instructions. Should any difficulty arise regarding their interpretation or application then the advice of the Director of Finance or authorised nominee must be sought before action is taken.
- 1.11 It is the duty of the Chief Executive, managers and heads of department, to ensure that existing staff and all new appointees are informed of their responsibilities within these Instructions. Breaches of these Instructions will be reported to the Director of Finance.
- 1.12 Within these SFI's it is acknowledged that the Chief Executive is ultimately accountable to the Board for ensuring that NHSGGC meets its obligations to perform its functions within the available financial resources. The Chief Executive has overall responsibility for NHSGGC's activities and is responsible to the Board for ensuring that its financial obligations and targets are met.
- 1.13 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they will remain accountable to the Board for financial control. The Chief Executive is the Accountable Officer for NHSGGC's Finances, as set out in the Memorandum to National Health Service Accountable Officers by the SEHD in accordance with the Public Finance and Accountability (Scotland) Act 2000.
- 1.14 Without prejudice to the functioning of any other officer of NHSGGC, the Director of Finance will ensure:
 1. the design, implementation and supervision of systems of financial control including the adoption of Standing Financial Instructions and the maintenance of effective internal audit arrangements;
 2. the preparation, documentation, implementation and maintenance of NHSGGC's financial policies, procedures and systems in support of a comprehensive control environment;
 3. the co-ordination any corrective action necessary to further these policies, procedures and systems;
 4. the preparation and maintenance of such accounts, costs, estimates etc. for the purposes of carrying out NHSGGC's duties and establishing with reasonable accuracy NHSGGC's financial position;

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5. the provision of financial advice to NHGGC's Board and its officers;
 6. the accurate and timely submission to the Scottish Executive Health Department of Annual Accounts and such other reports, returns and monitoring information as may be required to allow the SEHD to discharge its responsibilities.
- 1.15 The Director of Finance may make minor changes to terminology contained in, or presentation of, these SFI's as required, without seeking approval. Any such changes will be reported to the NHS Board at the time of the annual review of these Instructions.
- 1.16 Wherever the title of Chief Executive or Chief Officer is used in these Instructions, it will be deemed to include such other directors or employees who have been duly authorised to represent them.
- 1.17 Whenever the term "employee" is used it shall be deemed to include directors or employees of third parties contracted to NHSGGC when acting on behalf of NHSGGC.
- 1.18 All references in these Instructions to the singular form will be read as equally applicable to the plural.
- 1.19 All references in these Instructions to the masculine gender shall be read as equally applicable to the female gender.
- 1.20 Any reference to any legislation, provision or guidance should be construed as applying equally to any amendment or later publication of that legislation, provision or guidance.

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SECTION 2

ALLOCATIONS, BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

2.1 NHSGGC will perform its functions within the total of funds allocated by Scottish Ministers and any other source of recognised income. All plans, financial approvals and control systems will be designed to meet this obligation.

2.2 ALLOCATIONS AND REVENUE PLAN

The Director of Finance will:

1. at least once per year, review the bases and assumptions used for distributing allocations and ensure that these are reasonable and realistic and secure NHSGGC's entitlement to funds;
2. submit to the Board for approval, prior to the start of each financial year, Financial Plans, for both revenue and capital expenditure, detailing sources of income and the proposed application of those funds, including any sums to be held in reserve;
3. ensure that the proposed application of funds reconciles to the allocations received and other sources of income;
4. ensure that the Financial Plan states clearly the significant assumptions on which it is based and details any major changes in activity, delivery of service or resources required to achieve the Plan;
5. ensure that the Financial Plan reflects the objectives set out in the Local Delivery Plan and the Local Health Plan .
6. report to the Board if the timetable for submission of the Financial Plan is delayed, and agree a revised timetable which will ensure submission before the start of the financial year or as soon as possible thereafter;
7. regularly report to the Board on significant changes to the initial allocation and the uses of such funds.

2.3 PREPARATION AND APPROVAL OF BUDGETS

2.3.1 Prior to the start of the financial year, and in accordance with a timetable agreed by the Board, the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will predominantly cover allocations to Divisions and Partnerships to provide services for the delivery of healthcare and will also identify funding required for the operation of the corporate functions of NHSGGC. Such budgets will:

1. be in accordance with the aims and objectives set out in the Local Health Plan;
2. accord with workload and manpower plans;
3. be produced following discussion with appropriate Division representatives and other budget holders;

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4. be prepared within the limits of available funds; and
 5. identify potential risks.
- 2.3.2 The Director of Finance will establish procedures to monitor financial performance against budget and the Financial Plan, periodically review them and report to the Board.
- 2.3.3 All budget holders, and managers, must provide information as required by the Director of Finance to enable budgets to be compiled and monitored, using as appropriately defined reporting formats.
- 2.3.4 The Director of Finance has a responsibility to ensure that adequate financial advice is provided on an ongoing basis to budget holders to help them discharge their budgetary control responsibilities effectively and efficiently.

2.4 BUDGETARY DELEGATION

- 2.4.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities.

This reflects the emerging nature of partnership working, both with other public sector organisations and private agencies providing healthcare services [See also Section 7 of these Instructions].

This delegation must be in writing and be accompanied by a clear definition of:

1. the amount of the budget;
 2. the purpose(s) of each budget heading;
 3. individual and group responsibilities;
 4. authority to exercise virement;
 5. achievement of planned levels of service; and
 6. the provision of regular monitoring reports.
- 2.4.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.
- 2.4.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.
- 2.4.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.
- 2.4.5 Any person committing NHSGGC to expenditure should either be the relevant budget holder or be specifically authorised to do so by the budget holder. Expenditure for which no provision has been made in an approved budget and not subject to funding under the delegated powers of virement shall only be incurred after authorisation by the Chief Executive, or the Director of Finance or the Board as appropriate.

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2.5 BUDGETARY CONTROL AND REPORTING

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

1. - Monthly financial reports available to the Board, in a form approved by the Board, containing:
 - income and expenditure to date showing trends and forecast year-end position;
 - movements in working capital materially affecting resource limits;
 - capital project spend and projected out-turn against plan;
 - explanations of any material variances from plan;
 - details of any corrective action where necessary;
 - an assessment of financial risk.
2. - the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering areas for which they are responsible;
3. - investigation and reporting of variances from financial, workload and manpower budgets;
4. - monitoring of management action to correct variances; and
5. - arrangements for the authorisation of in-year budget transfers.

2.5.2 Each budget holder is responsible for ensuring that:

1. any likely overspending or reduction of income, which cannot be met by virement, is not incurred without the prior consent as outlined in para 2.4.5 above;
2. the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement.

2.5.3 The Chief Executive is responsible for identifying and implementing efficiency and rationalisation programmes together with income initiatives in accordance with the requirements of the Financial Plan and any other guidance received from the SEHD from time to time and to thereby ensure a balanced budget.

2.5.4 Chief Operating Officers/Directors of each division/partnership must ensure that these budgetary control and reporting disciplines operate in their Division/partnership. This supports NHSGGC's overarching budgetary control environment.

2.6 MONITORING RETURNS

2.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the SEHD and any other statutory organisation as required.

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2.7 CAPITAL EXPENDITURE

- 2.7.1 The general rules applying to delegation and reporting shall also apply to capital expenditure including the requirement to stay within the Capital Resource limit [HDL (2002) 40 refers] [See also Section 12 of these Instructions].

2.8 SCHEME OF DELEGATION

- 2.8.1 The Board shall approve a Scheme of Delegation which will specify:

1. areas of responsibility;
2. nominated officers; and
3. the scope of the delegation in terms of financial value, time span etc.

The Scheme of Delegation will be reviewed and approved by the Board as part of the annual review of Corporate Governance arrangements.

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SECTION 3

ANNUAL ACCOUNTS AND REPORTS

- 3.1 The Director of Finance on behalf of the Board, will:
1. keep, in such form as the Scottish Ministers may direct, account of all monies received or paid out by NHSGGC;
 2. prepare financial returns in accordance with the guidance issued and regulations laid down by the Scottish Ministers, NHSGGC's accounting policies and generally accepted accounting principles;
 3. prepare, certify and submit Accounts in respect of each financial year as required by Section 86 (3) of the NHS (Scotland) Act 1978;
 4. ensure that Accounts are prepared in a format which meets the requirements of the Health Board Accounts Manual, recognise best accounting practice and such other legislation, directions and guidance as may be in force at the time;
 5. ensure that the Accounts are produced in accordance with the timetable set down by the SEHD and by the Auditor General.
 6. ensure that there is evidence of compliance with NHSGGC's Corporate Governance measures in accordance with NHS MEL (1999) 14, NHS MEL (1999) 83 and NHS HDL (2002) 11 on Corporate Governance: Statement on Internal Control, or subsequent extant guidance.
- 3.2 NHSGGC's Annual Accounts must be audited by an independent External Auditor (External Audit is dealt with at greater length in Section 4 of these Instructions).
- 3.3 The audited Accounts must be presented to and approved by the Board at a public meeting.

SECTION 4

AUDIT

4.1 AUDIT COMMITTEE

4.1.1 In accordance with Standing Orders and as set out in guidance issued under NHS Circular MEL (1994) 80, the Board will establish an Audit Committee which will provide an independent and objective view of internal control by:

1. overseeing internal and external audit services;
2. reviewing financial systems;
3. ensuring compliance with Standing Orders and these Instructions;
4. reviewing NHSGGC-wide systems of internal control and arrangements for Corporate Governance and reporting annually thereon to the Board; this report will be informed by the annual statement by Chief Internal Auditor, or Audit Manager where the internal audit service is outsourced, on the adequacy and effectiveness of internal controls - see paragraph 4.4.5.

In discharging these responsibilities, the Audit Committee will provide the appropriate assurance to Directors that the necessary controls are in place to allow the Chief Executive on behalf of the Directors, to sign the Statement on Internal Control in the Annual Accounts.

4.1.2 The Terms of Reference of the Audit Committee will be reviewed and approved annually by the Board.

4.1.3 Where the Audit Committee feel 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 Chairman 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 SEHD (to the NHSiS Director of Finance in the first instance).

4.1.4 The Director of Finance will be responsible for ensuring that an adequate internal audit service is provided and the Audit Committee will be involved in reviewing tenders and awarding contracts when the contract for internal audit services is renewed or changed.

4.1.5 The Director of Finance will be responsible for arranging the resources required to carry out any review or investigation which is commissioned directly by the Audit Committee under its Terms of Reference.

4.1.6 Two Audit Support Groups (ASG's), one covering the Corporate and Partnership functions (and chaired by the Director of Finance) and other the Acute Division (chaired by the Director of Finance – Acute Services), will monitor and follow up routine audit issues. The internal and external auditors will attend meetings of the ASG's. The ASG's will report details of their work to the Audit Committee, which will monitor their operation.

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4.2 EXTERNAL AUDIT

- 4.2.1 NHSGGC's Accounts must be audited by auditors appointed by the Scottish Ministers. Under the Public Finance and Accountability (Scotland) Act 2000, the Auditor General for Scotland will secure the audit of the Board's Accounts on behalf of the Scottish Ministers.
- 4.2.2 The audit will be carried out in accordance with the Audit Scotland Code of Audit Practice and such other relevant legislation, directions and guidance as may be in force at the time.
- 4.2.3 The external auditor will discharge his reporting responsibilities under the Audit Scotland Code of Audit Practice by providing the following outputs from the audit:-
1. an Audit Certificate on NHSGGC's Statement of Annual Accounts;
 2. a Final Report to Board Members;
 3. Management Letters and other reports to management as required.
- 4.2.4 The Director of Finance will ensure that:-
1. the external auditors receive full co-operation in the conduct of the audit;
 2. the Final Report to Board Members together with the audited Accounts are presented timeously to the Board for noting and adoption, and the adopted Accounts are subsequently forwarded to the SEHD;
 3. action is taken in respect of all recommendations contained in the external auditor's reports and letters in accordance with the timetable agreed with the external auditor.

4.3 DIRECTOR OF FINANCE

- 4.3.1 The Director of Finance is responsible for:
1. ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function headed by a Chief Internal Auditor/Audit Manager of sufficient status;
 2. ensuring that the internal audit service is adequate and meets NHS mandatory standards;
 3. ensuring that responses to internal audit reports are provided timeously and that internal audit recommendations are implemented as agreed.
 4. ensuring that, in cases of fraud, the NHSS Counter Fraud Service is notified without delay, in accordance with NHSGGC's Fraud Response Plan and the Partnership Agreement with NHSS Counter Fraud Services.
- 4.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property of NHSGGC, or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance, or the Fraud Liaison Officer appointed by him, must be notified immediately.
- 4.3.3 The Director of Finance will ensure that cases of fraud, misappropriation or other irregularities are investigated in accordance with the Fraud Response Plan approved by the Board.

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4.3.4 The Director of Finance will ensure that there is adequate communication between the external and internal auditors to avoid unnecessary overlapping of work.

4.4 INTERNAL AUDIT

4.4.1 The role of internal audit will be based upon the guidance contained in the NHS Internal Audit Standards issued by the SEHD. These standards are mandatory and specifically it will be the responsibility of the Chief Internal Auditor/Audit Manager to review, appraise and report upon:

1. the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
2. the adequacy and application of financial and other related management controls;
3. the suitability of financial and other related management data;
4. the extent to which NHSGGC's assets and interests are accounted for and safeguarded from losses of all kinds arising from:
 - (a) fraud and other offences (where malpractice is suspected, the Director of Finance should be notified immediately).
 - (b) waste, extravagance and inefficient administration, poor value for money or other causes;
5. the efficient use of resources;
6. the adequacy of follow up action to his reports;
7. post transaction monitoring of property transactions in accordance with the provisions of the NHS Property Transaction Handbook.

4.4.2 The Director of Finance or other officers, such as the Chief Internal Auditor/Audit Manager, Fraud Liaison Officer or NHSS Counter Fraud Staff acting on the Director of Finance's behalf [including staff of third parties if the internal audit service is outsourced] will be entitled, without necessarily giving prior notice, to require and receive:

1. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case there will be a duty to safeguard that confidentiality);
2. access at all reasonable times to any premises or land of NHSGGC;
3. the production or identification by any employee of any Board cash, stores, or other property under the employee's control; and
4. explanations concerning any matter under investigation.

4.4.3 The Chief Internal Auditor/Audit Manager will report directly to the Director of Finance, and copy all reports to him. The Director of Finance will ensure that appropriate responses are provided and action is taken in respect of all internal audit reports.

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1. the timetable for completion of reports and provision of responses will be as agreed between the Chief Internal Auditor/Audit Manager and the Director of Finance.
 2. where, in exceptional circumstances, the use of normal reporting channels would be seen as a possible limitation of the objectivity of the audit, the Chief Internal Auditor/Audit Manager will seek the advice of the Chairman of the Audit Committee or Chairman or Vice Chairman of the Board.
 3. failure to take any necessary remedial action within a reasonable period will be reported to the Chief Executive.
- 4.4.4 The Chief Internal Auditor/Audit Manager will normally attend Audit Committee meetings and has a right of access to the Chairman of the Board, all Audit Committee Members and other Members of the Board.
- 4.4.5 The Chief Internal Auditor/Audit Manager will prepare an annual audit report for consideration of the Audit Committee. The report must cover:
1. a statement on the adequacy and effectiveness of NHSGGC's internal controls based on the audit work undertaken during the year;
 2. major internal control weaknesses identified;
 3. progress on the implementation of internal audit recommendations;
 4. progress against the internal audit annual plan over the previous year.
- 4.4.6 The Chief Internal Auditor/Audit Manager will prepare a strategic audit plan for consideration and approval of the Audit Committee. The plan will normally cover a period of three years and will be based on an assessment of the risks facing NHSGGC. Each year the Chief Internal Auditor/Audit Manager should update the plan and re-present it to the Audit Committee for approval.
- 4.4.7 The Strategic Audit Plan will be translated into an agreed Annual Plan which identifies the specific subjects to be audited in the coming year including any provision for contingencies and ad hoc work.

SECTION 5

BANKING ARRANGEMENTS

5.1 GENERAL

5.1.1 The Director of Finance is responsible for managing NHSGGC's banking arrangements and for advising the Board on the provision of banking services and the operation of accounts, including the levels of delegated authority.

5.2 BANKING PROCEDURES

5.2.1 All funds will be held in accounts in the name of NHSGGC and accounts may only be opened by the Director of Finance.

5.2.2 Only authorised signatories may draw on these accounts. The Director of Finance will approve and maintain a list of authorised signatories for this purpose.

5.2.3 All transactions relating to Board business must be reflected through these accounts.

5.2.4 The use of Board funds for making personal loans or for cashing personal cheques is not permitted.

5.2.5 The Director of Finance is responsible for:

1. establishing bank accounts and Office of the Paymaster General (OPG) accounts;
2. establishing separate bank accounts for NHSGGC's non-exchequer funds;
3. defining the use of each account;
4. ensuring that payments made from bank accounts do not exceed the amount credited to the account except as detailed in section 5.3 below.

5.2.6 The Director of Finance will ensure that detailed written instructions on the operation of bank accounts will include:

1. the conditions under which each bank account is to be operated;
2. a list of those authorised to sign cheques or other orders drawn on NHSGGC's accounts, including specimen signatures and the level of authority delegated to each signatory;
3. a list of those authorised to authenticate electronic payments.

5.2.7 The Director of Finance must advise NHSGGC's bankers in writing of the conditions under which each bank account is to be operated. This will include a list of authorised signatories with specimen signatures and the level of authority delegated to each.

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5.2.8 The Director of Finance will advise NHSGGC's bankers of the conditions under which any on-line banking service to which NHSGGC subscribes is to be operated, including lists of those authorised to approve transfers between accounts and BACS payments to other bodies, together with levels of authority.

BANK ACCOUNTS

5.3.1 The balances of accounts holding exchequer funds should not exceed any limits that may be set, from time to time, by the SEHD. All surplus funds must be maintained in accordance with the banking guidelines issued by SEHD.

5.3.2 Bank accounts will not be permitted to be overdrawn, pooling arrangements on bank accounts maintained at the same branch in the same name and in the same right notwithstanding.

5.3.3 All procedures in relation to OPG banking must be operated in accordance with the provisions contained in the Paymaster Banking Services User Guide dated June 1996.

TENDERING AND REVIEW

5.4.1 The Director of Finance will review the banking arrangements of NHSGGC at regular intervals to ensure they reflect best practice and represent best value for money.

5.4.2 Banking services will be subject to the procurement procedures set out in Section 10 of these Instructions.

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SECTION 6

INCOME, SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 INCOME SYSTEMS

- 6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.
- 6.1.2 All staff charged with the responsibility administering monies have a duty to ensure that these funds are safeguarded and that any monies received are banked promptly.

6.2 FEES AND CHARGES

- 6.2.1 Where services are provided to external bodies, and the fees or charges are not determined by SEHD or by Statute, those responsible for that service must ensure that an appropriate charge is made. These charges should be reviewed annually. Independent professional advice on matters of valuation will be taken as necessary.
- 6.2.2 Employees entering into arrangements whereby fees are charged to a third party, must inform one of the following senior financial officers:-
1. the Director of Finance
 2. the Director of Finance - Acute
 3. the Head of Finance – Corporate Financial Reporting
 4. the Financial Services Manager
 5. the Head of Finance – Acute Services
 6. the Head of Finance – NHS Partnerships
- 6.2.3 Fees may be waived only on the authority of one of the aforementioned.

6.3 DEBT RECOVERY

- 6.3.1 The Director of Finance is responsible for ensuring that appropriate recovery action on all outstanding debts is taken.
- 6.3.2 Income not received/bad debts should only be written-off with the appropriate authority and dealt with in accordance with the losses procedures detailed in section 18 “Fraud, Losses and Legal Claims”.
- 6.3.3 Systems should be put in place to prevent overpayments, but where they do occur, overpayments should be detected and recovery initiated. Write-off of unrecovered amounts is also covered in section 18, as referred to above,

6.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

- 6.4.1 The Director of Finance is responsible for ensuring:
1. the approval of the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

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2. the appropriate ordering and secure control of any such stationery;
 3. the provision of adequate facilities and systems for employees whose duties include collecting and holding of cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
 4. that systems and procedures for handling cash and negotiable securities on behalf of NHSGGC are in place;
 5. that a system for the transportation of cash is in place.
- 6.4.2 The use of Board funds for making personal loans or for cashing personal cheques is not permitted.
- 6.4.3 Cash balances held on NHSGGC premises will be kept to the minimum required for the provision of NHSGGC services. Where there is any significant increase in the level of funds held (either official or unofficial), the approval of the relevant Chief Officer must be obtained.
- 6.4.4 All cheques, postal orders, cash orders, cash, etc. should be banked intact promptly, to the credit of the prescribed income or debtors account. Disbursements may not be made from cash received.
- 6.4.5 The holders of safe keys should not accept unofficial funds for depositing in their safes
- 6.4.6 Keys should be held on the keyholder's person or kept secure at all times. Keys should not be kept in, or on, desks (either hidden or otherwise). A spare key should be held off-site by a senior manager for instances where the keyholder has an unplanned absence. The senior manager will take adequate precautions surrounding the security of the spare key and will keep a record of any instances where it is issued.
- 6.4.7 During the absence (e.g. on holiday) of the holder of a safe or cash box key, the officer who acts in his place is subject to the same controls as the normal holder of the key. There should be a written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.
- 6.4.8 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 SFI 18 – Fraud, Losses and Legal Claims).

SECTION 7

**SERVICE PROVISION AND SERVICE LEVEL AGREEMENTS
(INCLUDING VOLUNTARY SECTOR ORGANISATIONS)**

- 7.1 The Board will approve, within the context of the Local Delivery Plan, the particular arrangements for healthcare services for the population on an annual basis. The Chief Executive is responsible for ensuring that
1. appropriate agreements are in place with healthcare service providers (both within and outwith the NHS);
 2. agreements for healthcare are made with due regard to the guidance on planning and priorities issued by the SEHD, as well as the need to achieve value for money and to minimise risk. Agreements must ensure that the agreed activity levels are appropriate in terms of the demand for services and NHSGGC's allocation.
- 7.2 Appropriate agreements should be in place for:
1. the provision of healthcare services NHSGGC by other NHS bodies and by bodies outwith the NHS; and
 2. the provision of healthcare services to other NHS bodies by the Board.
- 7.3 Where the healthcare services are provided to NHSGGC by another NHS Board, or where healthcare services are provided to another NHS body by NHSGGC, a Service Level Agreement (SLA) should be prepared specifying the level of activity expected of the provider and defining the funding arrangements.
- 7.4 Where services are provided by non-NHS organisations, a contract should be prepared specifying the services to be provided and the defining the full range of relevant terms and conditions. If appropriate, the advice of the NHS Scotland Central Legal Office should be obtained.
- 7.5 In addition, the Director of Finance will ensure that services have been procured in line with arrangements set out in these SFI's. The Director of Finance will ensure that:
1. there is a system to ensure the payment is related to satisfactory delivery of the required service, value for money is achieved and risks to the Board are eliminated or reduced ;
 2. all systems operate in such a way as to maintain patient confidentiality;
 3. the total value of healthcare agreements placed are within the resources available to NHSGGC.
 4. procedures are in place for the handling of charges in respect of Unplanned Activity Contracts (UNPAC's) and Out of Area Treatment Services (OAT's) in accordance with the guidance issued by the SEHD.
- 7.6 VOLUNTARY SECTOR ORGANISATIONS**
- 7.6.1 Where the Board provides funding to a voluntary sector organisation, the Board officer with lead responsibility for the project will ensure that the project meets the criteria set out in the Project Authorisation Checklist approved by the Audit Committee. The Project Authorisation Checklist will be signed in accordance with the Scheme of Delegation.

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SECTION 8

PAY EXPENDITURE

8.1 REMUNERATION

- 8.1.1 The Board will establish a NHSGGC Staff Governance Committee whose composition and remit will be approved by the Board.
- 8.1.2 The NHSGGC Staff Governance Committee will establish a Remuneration Sub Committee to consider the remuneration of the senior managers on the Executive Pay Arrangements within the NHSGGC area, to ensure consistent application of the methods of objective setting, appraisal of performance and remuneration decisions.
- 8.1.3 NHSGGC will remunerate the Chair and Non-executive Directors in accordance with the instructions issued by Scottish Ministers.

8.2 STAFF APPOINTMENTS, CHANGES AND TERMINATIONS

- 8.2.1 Directors or employees authorised to do so may engage, re-engage or regrade employees, or hire agency staff, only within the limit of their approved budget and financial establishment. All appointments must be in accordance with approved Human Resources and Staff Governance Policies.
- 8.2.2 All appointments, termination and change forms must be immediately sent to the Payroll Department. It is essential that a termination form is submitted to the Payroll Department in the prescribed form 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 that suggest that he has left without notice, the Payroll Department must be informed immediately.
- 8.2.3 Where contractors are used (as opposed directly employed staff), any contract awarded must demonstrate value for money and comply with procurement procedure in respect of SFI's on Orders, Quotations and Tenders. For the avoidance of doubt, the value to be considered, in this respect, is the total value of payments over the duration of the contract.

8.3 PROCESSING OF PAYROLL

- 8.3.1 The Director of Finance is responsible for ensuring:
1. that appropriate payroll services are provided to meet NHSGGC's needs;
 2. that there are appropriate operating policies and procedures in place to control all pay expenditure;
 3. that a list is maintained of all officers duly authorised to approve pay expenditure and changes;
 4. that only approved time records, pay sheets and other pay records and notifications are used.

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8.3.2 Regardless of the arrangements for providing the payroll service, the Director of Finance will ensure that the chosen method is supported by appropriate management arrangements, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to the appropriate bodies.

8.4 PROCESSING OF EXPENSES

8.4.1 The Director of Finance will ensure that all expenses claimed by employees of NHSGGC or outside parties are reimbursed in line with the relevant regulations. Claim forms for expenses will be in an approved format, and will be completed and authorised by an officer approved by the Director of Finance. Such forms will be accompanied by supporting vouchers and will be submitted timeously and/or in accordance with the agreed timetable.

8.5 AUTHORISATION

8.5.1 All payments to staff will be subject to authorisation by a budget holder or other officer with delegated authority to approve payroll expenditure in that area. Such authorisation should be based on adequate review and, where reliance is placed on the work of others to carry out this review, must, as a minimum, include specific review of any entries relating to officers whose work is being relied on.

8.5.2 In no circumstances should officers authorise/approve their own payroll input or expenses.

8.5.3 Once authorised, all payroll documents should be submitted directly to the Payroll department by the authorising officer. If this task is delegated, then steps should be taken to ensure that there are no amendments made following authorisation.

8.6 CONTRACT OF EMPLOYMENT

8.6.1 The Director of Human Resources is responsible for;

1. ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
2. ensuring that variations to, or termination of, contracts of employment are dealt with by the appropriate officer, in line with the procedure in place for such instances.

SECTION 9

NON-PAY EXPENDITURE

9.1 INTRODUCTION

9.1.1 All non-pay expenditure will be authorised, purchased and paid in accordance with these Standing Financial Instructions, ensuring that the NHSGGC achieves financial balance, procures best value for money goods and services, meets commercial best practice and complies with European and UK competition legislation.

9.2 STAFF RESPONSIBILITIES

9.2.1 The Director of Finance will ensure that:

1. all accounts and claims are properly paid;
2. the Board is advised on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained;
3. these thresholds are regularly reviewed;
4. that NHSGGC has a Construction Procurement Policy that is consistent with national policy and guidelines.

9.2.2 The Head of Procurement is responsible for ensuring the preparation, maintenance and issue of procedural instructions on the procurement of goods, works and services incorporating these thresholds;

9.2.3 All procurements will be administered by the Procurement Department unless specific delegated purchasing authority has been granted by the Chief Executive.

9.2.4 There must be segregation of duties between the activities of requisitioning, ordering, receipting and paying of goods and services. The Director of Finance and Head of Procurement will ensure that such segregation is in place at all times.

9.2.5 **All officers must comply with the Standards of Business Conduct.** If any officer of NHSGGC is aware of any personal interest, directly or indirectly, in any proposed contract or purchase, he must immediately declare such an interest in writing to his immediate supervisor or to the Chief Executive or his nominee. Any officer who has such an interest must not take part in the evaluation or authorisation of any part of the contract or purchase. **Guidance will be issued in support of the Standards of Business Conduct and this will be available to all staff.**

9.2.6 Any officer who is involved in any part of the contracting or purchasing process is responsible, as far as he is able, for ensuring that NHSGGC is only committed to contracts or purchases which are in accordance with NHSGGC's policies and which give NHSGGC maximum value for money when compared with any known alternatives.

9.2.7 No staff should make a binding commitment on behalf of NHSGGC unless they have the delegated authority to do so. Any authorised commitments must be in writing. Staff should be aware that the terms of the Requirements of Writing (Scotland) Act state that NHSGGC can be bound by a verbal undertaking given by an officer of NHSGGC in the course of business.

9.3 ACTIONING NON-PAY EXPENDITURE

9.3.1 Budgetary Control

9.3.1.1 No order will be placed or contract let for goods or services where there is no budget provision, unless authorised by the Director of Finance or the Chief Executive.

9.3.1.2 Contracts or orders will not be placed in a manner devised to avoid the financial limits specified by the Board.

9.3.2 Tendering and Quotations

9.3.2.1 All contracts and purchases will be tendered in accordance with SFI10 “Orders, Quotations and Tenders”, with the objective of securing goods and/or services of the necessary quality and quantity in accordance with NHSGGC's objectives and strategies at the most economic rates. All procurement must be carried out in accordance with all relevant National and EU regulations, directives and guidelines.

9.3.2.2 The European Union Consolidated Procurement Directive is applicable to all public sector organisations effective from the 31 January 2006. This regulation is prescriptive in its requirements for public sector organisations and these SFI's are designed to ensure NHSGGC's full compliance.

9.3.2.3 The Freedom of Information Act (2000) is applicable to public sector procurements where specific provisions and requirements with regard to disclosure of information apply and may override commercial sensitivities in some circumstances if deemed in the public interest. Given the potential for commercial prejudice therefore, and the risks to NHSGGC associated with compliance or non-compliance with the FOI Act, a structured and disciplined tender and contract award process taking into account FOI requirements shall apply in most circumstances. These SFI's set out appropriate responsibilities for designated officers with external commitment authority, who in turn shall ensure that tender and contract award processes meet the provisions and requirements of this regulation.

9.3.2.4 The Race Relations (Amendment) Act 2000 amends the provisions of the Race Relations Act 1976 and outlaws any racial discrimination, including any potential discrimination through the provision of goods and services. All public authorities therefore have a duty to take race equality into account when procuring goods, works, or services from external providers. These SFI's set out appropriate responsibilities for designated officers with external commitment authority, who in turn shall ensure that tender and contract award processes meet the legal provisions and requirements. (For further information refer to National Procurement Guidance Document for Race Equality and Procurement in NHS Scotland www.nationalprocurement.scot.nhs.uk/E-Diversity)

9.3.3 Contracts

9.3.3.1 By definition a contract is any agreement between NHSGGC and another party/parties that is enforceable by the law. Contracts can be formed orally, in writing or even by conduct.

9.3.3.2 Contracts will be entered into whenever they are considered to be in the best interests of NHSGGC and all purchases will be made from NHSGGC or National contracts, where available. All contracts will have a sound basis in law and appropriate commercial contract conditions must be chosen to minimise the risk of any adverse litigation. Where appropriate,

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National Standard Forms will be used and where contracts are not of a standard form, the Central Legal Office should be consulted.

9.3.3.3 All such contracts shall be approved and issued only by the Head of Procurement unless specific delegated authority has been granted by the Chief Executive or the Board.

9.3.4 Purchase Indents

9.3.4.1 Prior to any Official Order being raised a purchase indent must be submitted and approved in accordance with section 9.3.5 and 9.3.6 of these Instructions.

9.3.5 Authorisation

9.3.5.1 All indents and associated orders for the purchase of items must be properly authorised in accordance with these SFI's. The ordering/authorising officer is responsible for satisfying himself that NHSGGC's contracting and ordering instructions have been properly complied with before he signs an order and that the order does not commit NHSGGC to expenditure in excess of the budgeted amount.

9.3.5.2 The Director of Finance has responsibility, acting on behalf of the Chief Executive for the setting of financial limits.

9.3.6 Delegation Of Authority

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

9.3.6.2 Each operating unit will maintain a Scheme of Delegation and all employees must comply with the limits set in all aspects of non-pay expenditure. The Financial Governance and Audit Manager will be responsible for ensuring that schemes are consistent.

9.3.6.3 Indents/ Requisitions for supplies can only be authorised by the budget holder of the directorate or department (or someone formally delegated with that authority) where the expenditure is planned and covered by available funds. The Director of Finance will ensure that there is a list of authorised signatories maintained for this purpose.

9.3.7 Purchase Orders

9.3.7.1 Only NHSGGC's authorised ordering officers, as approved by the Director of Facilities, shall sign purchase orders.

9.3.7.2 No goods or services may be ordered without the use of NHSGGC's official order form, including electronic versions. No officer of NHSGGC is permitted to make commitments outwith the official indenting and ordering processes unless the goods or services being procured have been generally or specifically exempted from these processes by the Chief Executive or Director of Finance.

9.3.7.3 The Head of Procurement will be responsible for ensuring that suppliers are made aware of the official ordering process.

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9.3.8 Construction Procurement

9.3.8.1 All construction procurement will be made in accordance with NHSGGC's Construction Procurement policy.

9.4 PAYMENT OF ACCOUNTS

9.4.1 The Director of Finance will ensure that there are adequate systems and procedural instructions covering the procurement process and the procedures for the verification, recording and payment of accounts and claims payable. These procedures will ensure that:

1. properly authorised accounts and claims are paid promptly in accordance with the terms of the Late Payment of Commercial Debt (Interest) Act 1998 (and any subsequent amendments) and payment of contract invoices is in accordance with contract terms, or otherwise in accordance with national guidance;
2. payment shall only be made for good and services that have a corresponding official purchase order;
3. payment for goods and services is only made when goods and services are received and accepted (excepting as at 9.4.3 below).

9.4.2 Specifically the system will include checks that:

1. goods received are in accordance with those ordered and that prices are correct or within tolerances approved by the Director of Finance.
2. work done or services rendered have been carried out satisfactorily and are in accordance with the order and the agreed contract terms.
3. in the case of contracts for measured time, materials or expenses, time is verified, rates are in accordance with those quoted, and materials or expenses are verified for quantity, quality and price.
4. expenditure is in accordance with regulations and authorisations.
5. the account is arithmetically correct.
6. VAT is recovered where permitted by legislation
7. the account is in order for payment.

9.4.3 Payments should not normally be made in advance of need i.e. before the liability to pay has matured. However, there may be certain exceptional circumstances where it is in NHSGGC's interests to make such a payment. Under no circumstances should any advance payment be made where there is a risk to public funds.

9.4.4 The approval of the Director of Finance is required in any instances where payment for goods or services in advance is deemed to be required.

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- 9.4.5 Where a manager certifying accounts relies upon other managers to do preliminary checking, he shall ensure that those officers are competent to do so and, 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.
- 9.4.6 In the case of contracts for building or engineering works that require payment to be made on account during progress of the works, the NHSGGC will make payment based on receipt of a certificate from the appropriate technical consultant or manager. Certificates will be subject to such examination as may be considered necessary before authorisation by the Director of Facilities (or other Director responsible).
- 9.4.7 The Director of Finance may authorise advances on an imprest system for petty cash and other purposes as required. Individual payments must be restricted to the amounts authorised by the Director of Finance and must only be used for purposes where it is not appropriate to use the normal payment or payroll systems.

SECTION 10

ORDERS, QUOTATIONS AND TENDERS

10.1 BUDGET PROVISION

- 10.1.1 No order will be placed or contract let for goods or services where there is no budget provision unless authorised by the Director of Finance or the Chief Executive.

10.2 SPECIFICATION OF NEED

- 10.2.1 The approval of specifications for externally sourced products or services requirements and the approval of charges against specified budgets for all externally purchased products or services shall be the responsibility of budget holders and limits on budget holder's individual approval levels shall be specified in the Scheme of Delegation (SoD).
- 10.2.2 Budget holder approval of specifications for certain externally supplied products or services shall be delegated to Clinical Heads of Service or Managers of designated specialist support departments. Clinical Heads of Service or designated specialist support managers will be responsible for providing specification criteria under national contract, where required, and for ensuring that products meet required specifications.
- 10.2.3 Budget holders approval of charges against specified budgets for externally purchased products or services may also be delegated to nominated Project or other Health Board executive or senior managers as specified in Capital or Revenue budget setting and approval processes.

10.3 OFFICIAL ORDERS

- 10.3.1 No goods, services or works, other than purchases from petty cash, purchase cards or where particular supplies have been exempted by the Chief Executive or Director of Finance, will be ordered, except on an official order, and contractors will be notified that they should not accept orders unless on an official form.
- 10.3.2 The Head of Procurement will prescribe standard conditions of contract appropriate to each class of supplies and services and for the execution of all works. All contracts and orders entered into will incorporate these conditions.

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10.4 ORDERING PROCEDURE

- 10.4.1 Official orders will be consecutively numbered, in a form approved by the Head of Procurement and shall include information concerning prices or costs as he may require. The order shall incorporate an obligation on the supplier or contractor to comply with the conditions printed on the orders as regards delivery, carriage, documentation, variations etc.
- 10.4.2 Order/requisition forms shall only be issued to and signed by officers so authorised as identified within the Scheme of Delegation. Lists of authorised officers shall be maintained and a copy of such lists supplied to the Director of Finance on request.
- 10.4.3 Only Post Holders delegated by the Board shall be authorised to commit NHSGGC to commitments with external parties.
- 10.4.4 Orders shall not be placed in a manner devised to avoid the financial thresholds specified in this Instruction.

10.5 CONTRACTS

- 10.5.1 Where supplies and services of the type and quantity required are available on National, Regional or Local Contract, the order must be placed with a supplier designated in that contract. Only in exceptional circumstances and only with the authority of the Director of Facilities, shall supplies and services available on contract be ordered out-with contract. Such exception will be recorded and reported to the Director of Finance and relevant Audit Support Group. Use should also be made of other UK Public Sector available contracts where they provide best value of money.
- 10.5.2 Where approved Contracts exist for the same product or services, with more than one supplier, then the contracted supplier offering best value for money must be selected.
- 10.5.3 For works projects, tender lists will be compiled after consulting Constructionline or in accordance with any other requirements issued by the Scottish Executive.

10.6 TRANSACTIONS INVOLVING PROPERTY

- 10.6.1 All transactions involving property will be conducted in accordance with the procedures set out in the NHS Property Transaction Handbook and SFI 12 Capital Expenditure.

10.7 QUOTATIONS

- 10.7.1 Where the supply of goods or services is estimated to be less than £25,000, the following applies, subject to the provisions of paragraph 10.5 and 10.9:
- 10.7.1.1 **Expenditure less than £1,000:** The ordering officer should be able, by price comparison, to demonstrate that value for money is being obtained. Details of this should be written on/attached to the file copy of the order.
- 10.7.1.2 **Expenditure more than £1,000 but less than £5,000:** requires that prices (which need not necessarily be in writing) be obtained from 3 different companies; these will be retained in the Purchase file.

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10.7.1.3 **Expenditure more than £5,000 but less than £25,000:** At least three competitive quotations shall be obtained from different companies. Quotations must be in writing and retained for inspection. For complex or higher value items a specification should be prepared as appropriate.

10.7.2 Where quotes are obtained on the basis that the value of the supply was genuinely believed to be less than £25,000, but satisfactory quotes are returned marginally in excess of this amount, then the purchase may proceed subject to the completion of a waiver to tender form. In cases where it is anticipated that the cost may exceed £25,000, then formal tenders should be sought in accordance with paragraph 10.8

10.8 COMPETITIVE TENDERING

10.8.1 Where the supply of goods or services is estimated to be **£25,000** or above, the following applies except where other arrangements have been previously approved by the Head of Procurement.

10.8.2 Competitive tenders, which must have a formal specification, with a minimum of three tenders in each case, will be invited for the supply of all goods and services; building and engineering or works of construction and maintenance. All tendering documentation must be retained and filed for inspection

10.8.3 Rules for tendering are stated at 10.10, below. EU Directives must be adhered to where contract values are expected to exceed current EU limits.

10.8.4 The procurement of goods and services will not be sub divided into smaller lots in order to circumvent the requirement to obtain competitive quotations or tenders.

10.9 WAIVING OF TENDER/QUOTATION PROCEDURE

10.9.1 In the following exceptional circumstances, except in cases where EU Directives must be adhered to, **a Director, as specified in the Scheme of Delegation**, can approve the waiving of the above requirements:

1. where a the repair of a particular item of equipment can only be carried out by the manufacturer;
2. where the supply is for goods or services of a special nature or character in respect of which it is not possible or desirable to obtain competitive quotations or tenders;
3. a contractor's special knowledge is required;
4. where the Chief Executive has approved negotiation with a single tenderer; this must be evidenced in writing;
5. where the number of potential suppliers is limited, and it is not possible to invite the required number of quotations or tenders, or where the required number do not respond to an invitation to tender or quotation to comply with these SFI's;
6. where, on the grounds of urgency, or in an emergency, it is necessary that an essential service is maintained or where a delay in carrying out repairs would result in further expense to NHSGCC.

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- 10.9.2 Where goods and services are supplied on this basis, and the value exceeds £5,000, a "Waiver of Tender/Quotation" form should be completed, and signed by the appropriate director and the Head of Procurement; in the case of 1, 2, 3, 4 and 5 above, this must be completed in advance of the order being placed, but may be completed retrospectively in the case of 6.
- 10.9.3 The Head of Procurement will maintain a record of all such exceptions, and will supply details to the relevant Audit Support Group.
- 10.9.4 When goods or services are being procured for which quotations or tenders are not required and for which no contract exists, it will be necessary to demonstrate that value for money is being obtained. Written notes/documentation to support the case, signed by the responsible Budget Holder, must be retained for audit inspection.

10.10 TENDERING PROCEDURE

10.10.1 Advertising

NHSGGC requires adequate advertising of future requirements for goods and services as follows:

1. all supplies covered by the EU Public Procurement legislation will be advertised in accordance with the requirements of that legislation.
2. all other supplies which have an aggregated contract / order value of greater than £50k shall be advertised on the NHSGG internet site a minimum of 2 weeks ahead of drawing up tender lists. In exceptional circumstances the Head of Procurement can waive the requirement.
3. for all requirements for 'Products and Services' with an annual or contract term value of £93,738, the requirement shall also be submitted electronically in the required format for Advertisement in the OJEU Journal in accordance with the regulated timescales and procedures.

10.10.2 Selection of Tenderers

Tenderers will be selected based on their ability to meet minimum qualification criteria. This shall normally include financial standing, technical competence and operation capability.

10.10.3 Issue of Tender Documents

- 10.10.3.1 All tender documents shall be sent to prospective suppliers with return labels issued by NHSGGC which will be addressed to the Head of Procurement, NHS Greater Glasgow & Clyde, and shall be marked "Tender for(title of tender)" but shall not bear the name or identity of the sender. Suppliers will also be issued with comprehensive instructions regarding the return of the documents including any related bills of quantities. These instructions shall specifically forbid the supplier from marking the tender envelopes in a manner that indicates the sender or from associating the tender envelope with any related bill of quantity.

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10.10.3.2 The Head of Procurement will be notified of any tender documents issued along with the closing date and time for opening the tenders.

10.10.4 The Register of Tenders

10.10.4.1 A Register of Tenders will be kept in a sequentially numbered bound tender receipt book. The tender receipt book will be considered controlled stationery, under the control of Head of Procurement who will issue to staff authorised to receive tenders on behalf of NHSGGC and record such issues.

10.10.4.2 The following details should, as a minimum, be recorded in the Register of Tenders:

1. details of the subject of the tender
2. closing date and time of receipts
3. date and time of opening of tenders with reasons for any differences from closing date and time
4. tender references sufficient to trace details of invitation to tender or details of open tender
5. amounts
6. names and signatures of the Head of Procurement's representatives and
7. Independent witness.

10.10.5 Receipt and Safe Custody of Tenders

10.10.5.1 Tender envelopes shall be stamped and held unopened in a secure container until after the closing date or time. A register of tenders received will be maintained at the point of receipt. This will record the date and time of receipt and also the contract that the tender relates to.

10.10.5.2 An identifying reference will be written on the envelope and entered in the register.

10.10.5.3 Tenders will be opened, as soon as possible after the stated closing date and time, by the Head of Procurement or his nominated representative, in the presence of an independent witness of senior status. Both parties will initial each tender document opened.

10.10.5.4 All relevant details of tenders received, including the tendered cost, where specified will be entered in the Register of Tenders which shall be signed by the Head of Procurement or his nominated representative and the independent witness.

10.10.5.5 Where it is clearly in the interests of NHSGGC, late, amended, incomplete or qualified tenders may be considered. In such circumstances, a full report should be made to the Chief Executive, who will have authority to admit such tenders. Where a company invited to tender requests a delay in the submission, any deferment approved shall be notified to all the companies concerned.

10.10.5.6 The Head of Procurement will be notified of the date and time of all meetings arranged for the purpose of adjudicating tenders.

10.10.5.7 The Director of Finance has the right to inspect records of tenders to be received at any time in order that an auditor and/or a member of the Finance Department may attend the

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opening. The Director of Finance or his representative is not required to give any notice of attendance at tender openings.

10.10.6 Tender Acceptance

10.10.6.1 Where competitive tenders have been obtained, the most economically advantageous shall normally be accepted. A written report must be produced on the circumstances of the decision, and submitted to the Head of Procurement.

10.10.6.2 Any 'in-house' bids must be submitted and evaluated on exactly the same basis as bids from outwith NHSGGC.

10.10.7 Form of Contract Award

Dependant on the nature of the procurement, an official order and/or a letter of acceptance should be issued for every contract resulting from an invitation to tender. Unsuccessful tenderers will be notified in writing.

10.11 CONTRACT REGISTER / RECORDS

10.11.2 The Head of Procurement shall maintain a register of all contracts awarded by virtue of the circumstances detailed at paragraphs 10.8 and 10.9 above. Such a register shall be open to audit on an annual basis under the direction of the Finance Director or Chief Executive.

10.11.3 Retained files, of all authorised requisitions, purchase orders and contracts, either in paper or in electronic form shall be kept by each designated procurement department in accordance with audit and HM Customs and Excise requirements.

10.12 STANDARDS OF BUSINESS CONDUCT

10.12.1 The Standards of Business Conduct for NHS Staff include specific guidance on the acceptance of gifts and hospitality in relation to NHSGGC's commercial dealings. These Standards have been incorporated into the contract of employment of each member of staff. A copy of the relevant NHS Circular should be enclosed with each employee's contract of employment and are attached at Appendix 1.

10.12.2 The Standards state that "It is a long established principle that public sector bodies which include the NHS, must be impartial and honest in the conduct of their business and that their employees must remain beyond suspicion. It is an offence under the Prevention of Corruption Acts 1906 and 1916 for an employee to corruptly accept any inducement or reward for doing, or refraining from doing anything in his or her official capacity". It further states 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".

10.13 TRIAL/LOAN PRODUCTS

Products e.g. medical equipment, shall not be taken on trial or loan from suppliers or contractors unless authorised in accordance with these SFI's and the scheme of delegation and/or approved by the appropriate procurement department to ensure any arrangements are consistent with purchasing policy and do not commit the Health Board to a future uncompetitive purchase.

SECTION 11

STORES

- 11.1 The Head of Procurement is responsible for the control of stores, except for:
1. pharmaceutical stock, which is the responsibility of the Director of Pharmacy; and
 2. laboratories, radiography, occupational therapy, which are the responsibility of the senior manager in each of those departments.
- 11.2 The Head of Procurement will ensure that there are adequate arrangements in place to monitor and control the performance of any third party supplying storage and distribution services for stock owned by the Board.
- 11.3 Responsibility for security arrangements and the custody of keys for all stores locations should be clearly defined in writing and agreed with the designated manager, as referred to in 11.1 or the Head of Procurement.
- 11.4 All stores systems and records should be in a form specified by the Head of Procurement or Director of Finance. NHS Circular SHHD/DGM/(1990) 82 stipulates the basis for stores accounting. Where practicable, stocks should be marked as Board property.
- 11.5 Records should be maintained of all goods received and a delivery note should be obtained from the supplier at the time of delivery and should be signed by the person receiving the goods. The acceptance and recording of goods received should be independent of those that requisitioned/ordered the goods. Instructions should be issued to staff covering the procedure to be adopted in respect of:
1. where the quantity delivered does not agree with that ordered;
 2. where the quality/specification is unsatisfactory or not in accordance with the order;
 3. where no delivery note is available; and
 4. notification of suppliers of unsatisfactory deliveries.
- 11.6 All issue of stores must be supported by a requisition, authorised by the appropriate Budget-holding manager (or delegated officer). The Head of Procurement must be notified of all authorised signatories and their delegated authorities. The receiving department should acknowledge receipt of stores, this must be returned to the Stores Department independent of the storekeeper.
- 11.7 All transfers and returns should be recorded in a form approved by the Head of Procurement.
- 11.8 Breakages, obsolete stock and other losses of goods in stores should be recorded as they occur and a summary presented to the managers identified as responsible in 11.1 on a regular basis.
- 11.9 Stocktaking arrangements should be agreed with the Director of Finance or the Financial Services Manager, and a physical check covering all items in store performed at least once a year. The physical check should involve at least one officer other than the storekeeper. The stocktaking records should be numerically controlled and signed by the officers undertaking the check. Any surpluses or shortages revealed in stocktaking should be reported immediately to the Head of Procurement, who will investigate as appropriate. Known losses of stock items not on stores control should also be reported to the Head of Procurement. The Head of Procurement will report all losses to the Director of Finance on an annual basis, or immediately if significant or caused by fraud or theft.

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- 11.10 Where continuous stocktaking is performed, with all stock items having been covered at least once during the year (and higher value items more frequently) and the results of these checks have proved satisfactory, it may not be necessary to carry out a full stock count. Where it is proposed not to carry out a full stock count, the permission of the Director of Finance and the agreement of the external auditors must be sought in advance.
- 11.11 Where a complete system of stores control is not justified, e.g. family planning stock, alternative arrangements shall require the approval of the Financial Services Manager .
- 11.12 The designated manager, as referred to in 11.1 shall be responsible for ensuring there is an effective system for a review of slow moving and obsolete items and for condemnations, disposal and replacement of all unserviceable articles. These should be reported to the Director of Finance for recording in the Register of Losses (see SFI 18 – Frauds, Losses, and Legal Claims) and written down to their net realisable value.

SECTION 12

CAPITAL INVESTMENT

12.1 GENERAL

12.1.1 Capital Planning and Approval Processes were delegated to Health Boards in 2002 [HDL (2002)40 refers]. These Instructions reflect the inherent responsibility of Boards to manage their capital needs from within a single capital resource allocation.

12.1.2.1 These Instructions should be read in conjunction with the Scottish Capital Investment Manual issued by the SEHD and NHSGGC's Construction Procurement Policy. For property transactions, the relevant guidance is contained in the NHS Property Transaction Handbook. The requirements for the preparation of business cases remains contained in the relevant sections of MEL (1998)46, although this is due to be updated by SEHD.

12.2 CAPITAL INVESTMENT

12.2.1 The Chief Executive will ensure that there is a Capital Planning Group (CPG) in place, with the responsibility for the development and maintenance of the Board's Capital Plan.

12.2.2 The role and remit of the group will include the responsibility to:

1. establish priorities for the allocation of capital resources, preparing the Capital Plan and submitting this for approval to the NHS Board.
2. oversee the allocation of capital resources to projects in line with Board approval(s).
3. allocate any residue of available capital resources, including slippage which is identified by Directorates/CHPs/other partnerships during the course of the financial year.
4. monitor capital expenditure compared to plan, preparing revised forecasts and report progress to PRG/NHS Board on a quarterly basis.
5. review business cases, as required, prior to submission for PRG approval.

12.2.3 The CPG will be chaired by the Board's Director of Acute Services Strategy Implementation and Planning. Its membership would include the Chief Operating Officer (Acute), CHP Directors, Mental Health Partnership Director, Head of Service Planning, Head of Capital Planning and Procurement and Head of Finance (Capital and Planning), together with those with lead responsibility for capital programme management across Acute and Partnerships, and Property Disposals/Acquisitions. The Director of IM&T could also be a member of the Group and the Director of Finance (Corporate and Partnerships) and Director of Finance (Acute) would be available to attend as required. The CPG will meet quarterly during the year.

12.2.4 The Director of Finance will ensure that for every capital expenditure proposal, the CPG will be provided with assurance that the financial consequences, both capital and revenue, of the proposal have been fully detailed in the business case, and are within the constraints of the Financial Plan.

12.2.5 The Director of Acute Services Strategy Implementation and Planning will:

1. at least once per year, review the bases and assumptions used for allocating capital funds. This review will include proposals for which business case approval has been given and will note as relevant any timing considerations. Such requirements will be considered alongside requirements to meet on-going equipment (including ICT), plant and buildings renewals;
2. submit to the Board for approval at any early stage in each financial year, a Capital Investment Plan detailing sources of funding and proposed allocation, including any sums to be held in reserve;
3. ensure that the Capital Plan reflects the objectives set out in the Local Health Plan

The Director of Acute Services Strategy Implementation and Planning will regularly report to the Board on significant changes to the initial allocation and the uses of such funds.

12.2.6 **Commitment of Expenditure**

A scheme of delegation will operate based on the principles listed in above. This will allow Directorates, CHPs etc to proceed to commit to expenditure on approved allocations. It is proposed that the scheme of delegation will operate as follows:

12.2.6.1 **Non IM&T Schemes**

1. For individual schemes up to £1.5million, full devolved power to authorise expenditure is made available, with no requirement for PRG approval. For schemes within this category, where the financial value exceeds £500,000, a mini business case should be prepared and approved locally.
2. For individual schemes with a value between £1.5million and £5million, a mini business case should be prepared and submitted for approval by PRG.
3. For individual schemes with a value between £5million and £10million, a business case should be prepared and submitted for approval by PRG.
4. For individual schemes with a value of £10million and above, a business case will require to be prepared and submitted for NHS Board approval, prior to submission to SEHD for approval, as before. The contents of the business case will be consistent with extant SEHD guidance.

12.2.6.2 **IM&T Schemes**

1. For individual schemes of value up to £500k, devolved power to commit expenditure is given to the ICT Programme Board of the NHS Board.
2. For individual schemes of value £500k up to £1 million, a mini business case should be prepared and submitted for approval by PRG.
3. For individual schemes of value in excess of £1 million, up to £2 million, a business case should be prepared and submitted for approval by PRG.

4. For individual schemes of value in excess of £2 million, a business case will require to be prepared and submitted for NHS Board approval, prior to onward submission to SEHD for approval, as before. The contents of the business case will be consistent with extant SEHD guidance.

12.2.7 Content of Business Cases

The proposed content for business case submissions is detailed below:

12.2.7.1 Mini Business Case

This should provide an explanation for the capital proposal, providing key points on each of the following headings, as applicable:

1. description of proposal;
2. statement of strategic fit;
3. summary of options considered (including assessment of relative strengths and weaknesses, leading to identification of preferred option);
4. summary of implementation plan with key milestones;
5. financial analysis, including summary of capital and revenue cost implications and proposed source(s) of funding;
5. risk assessment (including plan for managing implementation and financial risk).

For guidance, it is anticipated that a mini business case should be a document comprising between 2 and 5 pages.

12.2.7.2 Business Case

This should provide an explanation for the Capital proposal, providing key points on each of the following headings, as applicable:

1. description of proposal;
2. statement of strategic fit;
3. detailed option appraisal, explanation of alternative options reviewed against a set of pre-agreed criteria and scoring summary;
4. financial appraisal, including summary of capital and revenue cost implications of alternative options;
5. overview of preferred option;
6. summary of implementation plan for preferred option with key milestones;
7. summary of benefit of preferred option;
8. risk management - plan for management of implementation and financial risks associated with preferred option.

For guidance, it is anticipated that a business case should be a document comprising between 5 and 10 pages.

- 12.2.8 The Director of Finance will ensure that procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes are issued.

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12.3 PRIVATE FINANCE

- 12.3.1 The guidance relating to Public Private Partnerships (PPP) contained in the Scottish Capital Investment Manual should be regarded as part of these Instructions.
- 12.3.2 The Board will determine the nature and process of its scrutiny of PPP proposals. The role of the Board will be agreed from time to time in accordance with whatever guidance may be in force either locally (from the Chief Executive) or nationally (from the SEHD).

12.4 MAJOR CAPITAL INVESTMENT

- 12.4.1 For all major capital investment projects (currently defined as those with capital value over £1.5 million, including fees and VAT), NHSGGC will, in addition to the above, adhere to the following national mandatory requirements.

NHSGGC will also:

1. practice risk management, value management and whole life costing when procuring construction projects funded from public capital;
 2. approve all construction projects using a whole life cost plan against which periodic post occupation whole life cost analysis should be compared;
 3. subject projects to a cost analysis of the construction cost element at construction tender acceptance stage;
 4. subject projects to a post project evaluation, normally within six months of client occupation;
 5. subject projects to a post occupancy evaluation at occupation plus 2 to 3 years;
 6. appoint an Investment Decision Maker, Project Owner and a suitably experienced and trained Project Sponsor;
 7. support the Project Sponsor with a Client adviser where necessary and with a suitably qualified Project Manager.
- 12.4.2 In addition to mandatory requirements relating to individual major capital investment projects, further requirements dictate that NHSGGC must:
1. have a construction procurement policy consistent with and supportive of the SEHD's policy and guidance;
 2. subject its major occupied buildings to an annual occupancy cost analysis;
 3. contribute to and participate in wider actions which support the policy aims including the publication of outcomes arising from major capital investment projects to assist benchmarking and life long learning purposes;
 4. consider all relevant means of assessing construction procurement performance including benchmarking and performance indicators
 5. contribute to the Department of the Environment, Transport and the Region's (DETR) construction industry client key performance indicators.

SECTION 13

ASSETS

13 ASSETS

13.1 Assets include all property of NHSGGC including physical assets, such as buildings, equipment, vehicles, stores, cash, and intangibles such as intellectual property or goodwill. All staff have duty to protect and safeguard the assets of NHSGGC in the performance of their duties and it is the responsibility of the Chief Executive to ensure that adequate systems are in place to maintain satisfactory control of fixed assets. All transactions involving property will be conducted in accordance with the procedures set out in the NHS Property Transaction Handbook and SFI 12 Capital Expenditure.

13.2. ASSET REGISTERS

13.2.1 For the purposes of these Instructions, Fixed Assets will be defined in accordance with the guidance contained in the Scottish Capital Investment Manual and the Capital Asset Accounting Manual produced by the SEHD.

13.2.2 The Director of Finance will ensure that an Asset Register is maintained, and that all Fixed Assets are accurately and timeously recorded in the Register in accordance with the guidance contained in the Capital Asset Accounting Manual.

13.2.3 The Director of Finance will ensure that procedural instructions are prepared and implemented to ensure that:-

1. additions to the fixed asset register are clearly identified to an appropriate budget holder and 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; and
 - c. lease agreements in respect of assets held under a finance lease and capitalised;
2. where capital assets are sold, scrapped, lost or otherwise disposed of, their value is removed from the accounting records and each disposal validated by reference to authorisation documents and invoices(where appropriate);
3. balances on fixed assets accounts in ledgers are reconciled to balances on the fixed asset register;
4. the value of each asset is indexed to current values in accordance with methods as specified in the Capital Accounting Manual;
5. the value of each asset is depreciated using methods and rates as specified in the Capital Accounting Manual and is consistent with the agreed depreciation policy of NHSGGC;
6. capital charges are calculated and paid as specified in the Capital Accounting Manual.

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13.3 SECURITY OF ASSETS

13.3.1 The Director of Finance will ensure that procedures for the control of assets (including fixed assets, cash, cheques and negotiable instruments) are prepared and implemented. These procedures will make provision for the:

1. recording of managerial responsibility for each asset;
2. identification of additions and disposals;
3. identification of all repairs and maintenance expenses;
4. physical security of assets;
5. periodic verification of the existence of, condition of, and title to, assets recorded;
6. identification and reporting of all costs associated with the retention of an asset; and
7. reporting, recording and safekeeping of cash, cheques and negotiable instruments.

13.3.2 The Director of Finance will ensure all discrepancies revealed by verification of physical assets to the fixed asset register are investigated in accordance with the procedures set out in Section 18 of these Instructions.

13.3.3 Whilst each employee has a responsibility for the security of property of NHSGGC, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

13.3.4 Any damage to NHSGGC's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses (Section 18 of these Instructions).

13.3.5 Where practical, assets should be marked as NHSGG property.

13.3.6 On the closure of any premises, a physical check will be carried out and a responsible officer designated by the Chief Executive will certify a list of items held showing their eventual disposal.

13.4 DISPOSAL OF ASSETS

13.4.1 All disposals of assets should secure maximum income for NHSGGC (or minimise the cost where the disposal has no proceeds. Assets with an estimated value greater than £1,000 should be disposed of on the open market with arrangements commensurate with the value of the disposal. Under this level, the responsible manager must record and demonstrate that the best outcome for NHSGGC has been obtained. Where the disposal incurs a cost to NHSGGC, it should be dealt with in accordance with SFI 10 Orders Quotations and tenders.

13.4.2 Where a disposal is made to a related party (i.e. other than at "arms length") the circumstances should be reported to the Head of Procurement for approval and entry in the register of Exceptions to Tender.

13.4.3 The above does not apply to the disposal of heritable property, which must be disposed of in accordance with the relevant guidance contained in the NHS Property Transaction Handbook.

SECTION 14

FINANCIAL INFORMATION MANAGEMENT

14.1 CODE OF PRACTICE ON OPENNESS AND FREEDOM OF INFORMATION

14.1.1 The Code of Practice on Openness was produced by the NHS in Scotland Management Executive and sets out the basic principles underlying public access to information about the NHS in Scotland. All staff have a duty to comply with the Code.

14.1.2 The Freedom of Information (Scotland) Act 2002 (FOISA) places an obligation on public bodies to provide information, subject to certain exemptions (such as personal information etc.), to anyone who asks for it. Any request for information in permanent form (i.e. non verbal) is a FOISA request and must be responded to, within 20 working days. A number of officers throughout NHSGGC have been trained in the requirements of FOISA. Anyone receiving a formal request for information should immediately pass it to one of the FOISA trained officers or, alternatively, the appropriate Head of Administration.

14.1.3 Staff should continue to respond timeously to general requests for information, where it has been customary to do so, without reference to FOISA officers.

14.2 CONFIDENTIALITY AND SECURITY

14.2.1 All employees have a responsibility to treat as confidential information which may be available to them, obtained by them or derived by them whilst employed by NHSSGHC. They should not breach this duty of confidence by disclosing confidential information, using it in an unauthorised manner, or providing access to such information to unauthorised individuals or organisations.

14.2.2 Executive Directors and Heads of Department are responsible for the security and accuracy of data relating to his/her area of responsibility. In particular, the Director of Finance is responsible for the security of NHSGGC data processed and stored by information systems designed or procured under his responsibility. He is responsible for ensuring the accuracy and security of NHSGGC's financial data, including that held on and processed by computer.

14.2.3 In discharging these responsibilities, Directors should follow the guidelines contained in NHS MEL (1992) 45 - Computer Security Guidelines.

14.2.4 These instructions should be read in conjunction with:-

1. the Computer Misuse Act 1990;
2. the Data Protection Act 1998;
3. the guidance on safeguarding personal data relating to contracting process contained in NHS MEL (1992) 14 and NHS MEL (1994) 42;
4. the Code of Practice issued by the Scottish Office Home and Health Department in respect of the Confidentiality of Personal Health Information;
5. NHS MEL (1999) 19 - Caldicott Guardians.

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14.3 CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

14.3.1 Under the terms of NHS MEL (1999) 19 and subsequent guidance issued by the SEHD, NHSGGC has nominated the Medical Director as the Caldicott Guardian to “safeguard and govern the uses made within NHSGGC of patient identifiable information including both clinical and non clinical information.”

14.4 RESOLUTION OF CONFLICT

14.4.1 The Director of Finance and/or the Medical Director must be consulted in the event of a conflict arising between NHSGGC's obligations under the Code of Practice on Openness/FOISA and the need to maintain confidentiality.

14.5 COMPUTERISED FINANCIAL SYSTEMS

14.5.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of NHSGGC, will ensure that:

1. procedures are devised and implemented to ensure adequate protection of NHSGGC's data, programs and computer hardware, for which he is responsible, from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;
2. adequate controls exist over data entry, processing, storage, transmission and output, to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
3. adequate controls exist such that the computer operation is separated from systems development, maintenance and amendment;
4. an adequate audit trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

14.5.2 The Director of Finance will ensure 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.

14.5.3 The Director of Finance will ensure that contracts for computer services for financial applications with another health organisation, other agency or external supplier shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract will also ensure the rights of access for audit purposes and the Director of Finance will periodically seek assurances that adequate controls are in operation.

14.5.4 Where computer systems have an impact on corporate financial systems, the Director of Finance must be satisfied that:

1. the acquisition, development and maintenance of such systems are in line with corporate policies including NHSGGC's ICT Strategy;
2. data produced for use with financial systems is adequate, accurate, complete and timely, and that a management audit trail exists;

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3. finance staff have access to such data; and
4. such computer audit reviews as are considered necessary are being carried out.

14.5 **RETENTION OF RECORDS**

14.5.1 Records should be retained in accordance with the guidance contained in:-

- HDL (2006) 28 - The Management, Retention and Disposal of Administrative Records;
- Public Records (Scotland) Act 1937;
- Data Protection Act 1998;
- Freedom of Information (Scotland) Act 2002;
- Caldicott Review of Patient Identifiable Information 1997;

or any other relevant laws or regulations and subsequent instructions/guidance issued by the SEHD.

14.5.2 The Head of Board Administration will issue guidance on this matter as required and in cases of doubt his advice should be obtained.

SECTION 15

ENDOWMENT FUNDS

15.1 GENERAL

15.1.1 Endowment funds are defined as 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. The Directors of NHSGGC act ex officio as Trustees of the Endowment Funds.

15.1.2 The endowments are currently a Registered Scottish Charity in terms of the Charities and Trustee Investment Act 2005 and subject to the provisions of the Charities Accounts (Scotland) Regulations 2006.

15.2 APPROVAL OF EXPENDITURE

15.2.1 Expenditure from Endowment Funds is restricted to the purpose(s) of the appropriate Fund and can only be made with the approval of the Board of Directors as Trustees. Such approval will be delegated to the Director of Finance to authorise expenditure from General Funds against approved budgets.

15.2.2 Designated fundholders will be responsible for authorising/controlling expenditure incurred on those accounts for which they have designated fundholder responsibilities. They will be able to approve individual items of expenditure of up to £50,000. For individual expenditure items in excess of £50,000 up to a ceiling of £250,000, it will be necessary to obtain additional authorisation from two of the following:

Chief Executive
Director of Finance, Corporate and Partnerships
Chief Operating Officer, Acute Sector
Director of Finance, Acute Sector

For individual expenditure items in excess of £250,000, the approval of the Endowments Sub Committee of the NHS Board will be required.

15.2.3 Any expenditure incurred from Endowment Funds must comply with SFI 10 – Orders, Quotations and Tenders.

15.3 CUSTODY AND SECURITY OF ASSETS

15.3.1 All gifts must be held in NHSGGC's name in bank accounts specified for Endowments and withdrawals may only be sanctioned by authorised signatories. The Board of Trustees can only accept gifts for purposes relating to the NHS or research. In cases of doubt, the Director of Finance should be consulted.

15.3.2 All share and stock certificates and other assets relating to Endowment Funds will be held in the name of Nominees approved by the Trustees and will be deposited with the Endowment Funds' bankers or in some other secure facilities as determined acceptable to the Director of Finance. The Director of Finance will ensure a record is kept of all share and stock certificates on behalf of the Board of Trustees. Property deeds will be held by the Central Legal Office.

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15.3.3 Assets in the ownership of, or used by, NHSGGC as corporate trustee shall be maintained along with the general estate and inventory of assets of NHSGGC.

15.4 INVESTMENT

15.4.1 Endowment Funds will be invested by the investment managers appointed by the of the NHS Board. The investment managers will have full discretionary powers but subject to any restrictions that the trustees may impose from time to time.

15.4.2 The Board of Trustees, via the Endowments Sub Committee, will be responsible for:

1. the formulation of investment policy;
2. the appointment of investment managers and the review of their performance;
3. reporting of investment performance.

15.4.3 The Director of Finance will be responsible for all aspects of the management of the investment of funds held on trust, and will advise the Board of Trustees on the following:

1. participation in common investment funds;
2. authorisation for the use of trust assets.

15.5 CONTROL OF ENDOWMENT FUNDS

15.5.1 The Director of Finance will prepare and issue procedures in respect of NHSGGC funds. These procedures should cover the following matters:

1. governing instruments for every fund;
2. controls and authorisation to open new funds;
3. treatment of offers of new funds;
4. legacies and bequests;
5. controls over and authorisation of expenditure including lists of authorised signatories;
6. the accounts and records necessary to account for all transactions;
7. fund-raising;
8. trading income;
9. investment income;
10. periodic reporting of balances.

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15.5.2 The Director of Finance must ensure that:

1. the Board of Trustees is advised on banking arrangements and with Board approval, securing the appropriate banking services;
2. the Board of Trustees receive reports on receipt of funds, investment and any other matters agreed by the Board of Trustees;
3. annual accounts are prepared in the required manner within the agreed time-scales;
4. internal and external audit services are in place;
5. the Board of Trustees receive reports on the outcome of the annual audit;
6. the Funds' liability to taxation and excise duty is managed appropriately;
7. legal advice is obtained where necessary.

SECTION 16

FAMILY HEALTH SERVICES

16.1 INTRODUCTION

16.1.1 NHSGGC discharges its responsibility under Part II of the NHS (Scotland) Act 1978 by contracting the provision of Family Health Services to doctors, dentists, pharmacists and optometrists who are independent contractors.

16.2 INDEPENDENT CONTRACTORS

16.2.1 NHSGGC will maintain lists of approved contractors, and will make additions to, and deletions from, those lists, 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 of service.

16.2.2 NHSGGC will ensure that:

1. lists of all contractors, for which NHSGGC is responsible, are maintained and kept up to date;
2. systems are in place to deal with applications, resignations, and inspection of premises, etc., within the appropriate contractor's terms of service;
3. there are mechanisms to monitor the quality of services provided by contractors and where this is found to be unsatisfactory that appropriate remedial action is taken;
4. where a contractor is in breach of regulations, or whose service provision raises serious concerns, a report is submitted to the Reference Committee to consider disciplinary action;

16.3 PAYMENTS PROCEDURE

16.3.1 The Director of Finance will ensure:

1. that appropriate arrangements exist for payments to be made on behalf of NHSGGC by National Services Scotland;
2. payments are subject controls which include checks that:
 - (a) rules have been correctly and consistently applied;
 - (b) overpayments are prevented (or if not prevented, recovery measures are initiated);
 - (c) fraud is detected;

This will involve a combination of pre and post payment verification in line with nationally agreed protocols.

3. that arrangements are in place to identify contractors receiving exceptionally high, low or no payments, and highlight these for further investigation; and

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4. that a prompt response is made to any query raised by National Services Scotland – Practitioner Services Division regarding claims from contractors submitted directly to them
5. that controls and checks are in place to cover patients claiming exemption from NHS charges.
6. that any cases of contractor or patient fraud are investigated and criminal/civil/disciplinary action is taken where appropriate.

16.4 **FRAUD**

- 16.4.1 Any instances of suspected fraud or other financial irregularity must be reported in accordance with SFI 18, Fraud, Losses and Legal Claims.

SECTION 17

COMMUNITY HEALTH AND CARE PARTNERSHIPS/OTHER PARTNERSHIPS

- 17.1 Community Health and Care Partnerships (CHCPs) will provide and manage healthcare for their designated area in accordance with delegated authorities and budgets provided by NHSGGC and any participating Local Authorities. All NHSGGC employed staff and, any council employee managing NHSGGC funds, will comply with these Standing Financial Instructions.
- 17.2 Each CHCP will have an overlying financial governance framework, including a Scheme of Delegation, which will clarify the applicability of the policies and procedures of the participating bodies. This will not override, or dilute, the requirement that these SFI's must be complied with in respect of all NHSGGC funded activities.
- 17.3 All other partnerships will comply with the above principles.

SECTION 18

FRAUD, LOSSES AND LEGAL CLAIMS

18.1 FRAUD AND OTHER CRIMINAL OFFENCES

18.1.1 The Chief Executive, as Accountable Officer, is responsible for ensuring that all suspected fraud, theft, corruption and other financial irregularities are investigated and appropriate action taken. Operational responsibility for this is delegated to the Director of Finance and/or NHSGGC's Fraud Liaison Officer(s), who will take/instruct the necessary action and keep the Chief Executive apprised of any salient issues, or where controversy may arise. NHSGGC has a formal Fraud Policy, which sets out the Board's policy and individuals' responsibilities. The Policy is supported by a Fraud Action Plan which details the procedures to be followed when fraud, theft, corruption or other financial irregularities are suspected (ensuring compliance with circular HDL(2005)5). The following paragraphs provide an outline of the requirements but the Fraud Policy and relevant section of the Fraud Action Plan should be referred to for further detail.

18.1.2 The definitions of fraud, corruption and embezzlement (generally referred to as "fraud") and the related activity of theft are contained in the Fraud Policy, and are as follows:-

Fraud: the use of deception with the intention of obtaining an advantage, avoiding an obligation or causing loss to another party.

Corruption: the offering, giving, soliciting or acceptance of an inducement or reward which may influence the action of any person.

Embezzlement: the felonious appropriation of property by a person to which it has been entrusted.

Theft: the dishonest appropriation of the property of another with the intention of permanently depriving them of it.

18.1.3 NHSGGC will take appropriate legal and/or disciplinary action against any employee, director, contractor or other third party if any of the above offences are found to be proven. In instances where there is sufficient evidence to support a criminal prosecution there is a presumption that a referral will be made to the Procurator Fiscal for consideration.

18.1.4 Every officer has a duty to report, without delay, any instances of fraud, corruption, embezzlement, theft or other financial irregularities that they discover. This also includes any reasonably held suspicions that such circumstances have occurred (or are about to occur). This should normally be reported to the officer's line manager, in the first instance, but may be reported directly to the Director of Finance or Fraud Liaison Officer if there are concerns about reporting to the line manager. NHSGGC encourages anyone having reasonably held suspicions of fraud, or other irregularity, to report it. Individuals should have no fear of reporting such matters unless they know their allegations to be groundless and/or raised maliciously.

18.1.5 In cases where fraud, corruption or embezzlement is suspected, all investigations must be carried out by staff from NHSS Counter Fraud Service. Line managers must therefore contact the Director of Finance or Fraud Liaison Officer immediately to arrange preliminary discussions with NHSS Counter Fraud Service. No action should be taken, that may prejudice the outcome of any potential criminal prosecution, prior to consultation with the NHSS Counter Fraud Service. This does not however prevent immediate action being taken where there are issues regarding safety and/or suspicions that evidence may be destroyed. Further guidance is available in the Fraud Action Plan.

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- 18.1.6 In cases of theft, line managers should contact the Fraud Liaison Officer and the police. Local managers should assume that they have delegated authority to investigate minor thefts (subject to the approval of their service head) but should still contact the Fraud Liaison Officer to confirm this and to discuss any requirements for specialist assistance. Any major thefts, or theft involving some form of deception (which may require investigation by the NHSS Counter Fraud Service), should be discussed immediately with the Fraud Liaison Officer. There is a presumption that all thefts should be reported to the police and that the crime reference should be entered on the Incident Report Form IR1 and Loss Report. Managers must submit a copy of their formal investigation report (which will be satisfied by an IR1 or Loss Report in simple cases) to NHSGGC's Fraud Liaison Officer.
- 18.1.7 NHSGGC is not authorised to carry out any form covert surveillance. If any manager considers that such a measure is necessary to detect or prevent a crime then they should contact the Fraud Liaison Officer to arrange assistance from an authorised agency.
- 18.1.8 It is possible that any instance of fraud or other financial irregularity, may attract enquiries from the media or other outside sources. Staff should not make statements to the media regarding any financial irregularity, as this could prejudice the outcome of any criminal enquiry or proceedings. Any enquiries from the media or third parties should, in line with normal NHSGGC policy, be referred to NHSGGC's Communications Office, which will provide an appropriate response after consultation with the NHSS Counter Fraud Service and/or the Fraud Liaison Officer.

18.2 LOSSES AND SPECIAL PAYMENTS

- 18.2.1 The Director of Finance will ensure that procedural instructions on the recording of, and accounting for, condemnations, losses and special payments are prepared and issued.
- 18.2.2 Any officer discovering or suspecting a loss of any kind will immediately inform his local manager. The manager will complete a loss form which will be signed by a budget holder and submitted to Operational Financial Services. Losses in excess of the Budget Holder's delegated authority to write off losses should also be authorised by the appropriate Chief Operating Officers/Partnership Director. Where the loss is due to fraud or theft, the manager will immediately act as detailed at section 18.1 above.
- 18.2.3 The Director of Finance will ensure that a losses register in which details of all losses and compensations will be recorded as they are known is maintained.
- 18.2.4 The Board will approve the writing off of losses, within the limits delegated to it from time to time by the SEHD, except that delegated responsibility may be given by the Board to the Chief Executive or other officers. Any significant losses written off under this delegated authority will be reported to the Audit Committee (or Audit Support Group) of NHSGGC. Details of the delegated levels of authority are given in the Scheme of Delegation.
- 18.2.5 No losses or special payments that exceed the limits delegated to NHSGGC by the SEHD will be made without their prior approval.
- 18.2.6 The Director of Finance is authorised to take any necessary steps to safeguard NHSGGC's interest in bankruptcies and company liquidations.

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18.2.7 For any loss, the Director of Finance will consider whether

1. any insurance claim can be made against insurers; or
2. legal action can be taken to recover all or part of the amount of the loss.

18.3 CLAIMS FOR MEDICAL/CLINICAL NEGLIGENCE

The Head of Board Administration will arrange for the Acute Services Division and Partnerships to hold a register of claims for medical and clinical negligence including details of payments made.

18.4 OTHER LEGAL CLAIMS

The Head of Board Administration will arrange for the Acute Services Division and Partnerships to hold a register of other legal claims e.g. under Health and Safety legislation.

18.5 DISPOSALS AND CONDEMNATIONS

18.5.1 The procedures for the disposal of assets are set out in these instructions at Section 13 - Assets.

18.5.2 The Director of Finance will ensure that procedures for the recording and condemnation of all unserviceable items are prepared and issued.

SECTION 19

PATIENTS' PRIVATE FUNDS AND PROPERTY

19.1 PROCEDURE

19.1.1 NHSGGC has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, found in the possession of unconscious or confused patients, found in the possession of mentally disordered patients, or found in the possession of patients dying in hospital. Such property shall be dealt with as provided below and in accordance with the Adults with Incapacity (Scotland) Act 2000.

19.1.2 Patients or their guardians, as appropriate, shall be informed before or at admission by:

- notice and information booklets;
- hospital admission documentation and property records; and
- the oral advice of administrative and/or nursing staff responsible for admissions

that NHSGGC will not accept responsibility or liability for patients' property brought into Board premises, unless it is handed in for safe custody and a receipt is obtained acknowledging property handed over.

19.1.3 The Director of Finance will ensure that there are detailed written instructions on the collection, custody, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of property of deceased patients and patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. These instructions will incorporate the guidance on this subject issued from time to time by the SEHD.

19.1.4 Any money or property handed over for safekeeping will be evidenced by the issue of an official receipt.

19.1.5 Records of patients' property shall be completed by a member of the hospital staff in the presence of a second member of staff and in the presence of the patient or the personal representative, where practicable. It should be signed by the member of staff and by the patient, except where the latter is restricted by physical or mental incapacity, in which case it should be witnessed by the signature of a second staff member.

19.1.6 Patients' income, including pensions and allowances, shall be dealt with in accordance with current SEHD guidelines and Department of Work and Pensions regulations.

19.1.7 Where monies or valuables are handed in other than the Patients' Funds Cashier then they will be held securely and transferred to the Patients' Funds Cashier at the first reasonable opportunity.

19.1.8 Patients' funds will be banked and administered in accordance with instructions provided by the Director of Finance. Any funds not required for immediate use will be lodged in an interest bearing account with interest being credited to individual patients based on the level of funds held by each patient.

NHS Greater Glasgow & Clyde Standing Financial Instructions

- 19.1.9 In the case of patients incapable of handling their own affairs, and unless their affairs are managed under legal authority by some other party, their affairs will be supervised by a hospital Multi-disciplinary Review Team, following the guidance of the 1985 Report of the Working Party on Incapax Patients' Funds and in accordance with the Adults with Incapacity (Scotland) Act 2000.
- 19.1.10 In all cases where property, including cash and valuables, of a deceased patient is of a total value of more than £10,000 (or such other amount as may be prescribed by legislation and advised by the SEHD), production of a Confirmation of Estate will be required before any of the property is released. Where the total value of the property is less than £10,000, forms of indemnity will be obtained (although confirmation of estate may still be obtained in instance where dispute likely).
- 19.1.11 In respect of a deceased patient's property, if there is no will and no lawful kin, the property vests in the Crown, and particulars will, therefore, be notified to the Queen's and Lord Treasurer's Remembrancer.
- 19.1.12 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.

19.2 OUTSIDE CONTRACTORS

- 19.2.1 Where NHSGGC contracts with a private, voluntary sector or non NHS body for the provision of NHS patient care, the Director of Finance will ensure that the relevant contract specifies standards to be adopted for the administration and management of patients' private funds and property.
- 19.2.2 Detailed instructions, equivalent to those adopted by the Health Board, will be required and will form the basis of the standards required contractually of health care providers in respect of the administration and control of patients' funds and property. The Director of Finance will ensure the performance of partnership providers is monitored and measured against these procedures.

SECTION 20

USE OF MANAGEMENT CONSULTANTS

- 20.1 Where use of management consultants is being considered, the guidance of Circular NHS MEL (1994) 4 must be observed. This guidance covers the engagement, control and reimbursement of fees to management consultants.
- 20.2 The use of management consultants will be supported by formal statement indicating why use of a consultant is appropriate.
- 20.3 Engagement of management consultants must be carried out in accordance with SFI 10 – Orders, Quotations and Tenders and, where this is not possible, the reasons clearly documented along with a demonstration of value for money. Any single tenders/quotes must be authorised in accordance with that SFI.
- 20.4 Contracts will include:
1. description of work to be done and measure of completion;
 2. timescales;
 3. resources to be used by the management consultant;
 4. level of fees to be paid and timing of payment;
 5. level of expenses to be reimbursed, with limits and requirement for receipts;
 6. use of NHSGGC resources and confidentiality of information;
 7. ownership of documents produced on the assignment.
- 20.5 This does not apply to legal services, which must be obtained through the NHS Central Legal Office.

**NHS Greater Glasgow & Clyde
Draft Fraud Policy**

NHS Greater Glasgow & Clyde

Draft Fraud Policy

INTRODUCTION

This document sets out NHS Greater Glasgow & Clyde's (NHSGGC) policy in respect of fraud and related criminal offences (which for the purposes of this policy will be referred to generically as fraud). It is supported by: detailed guidance to staff on reporting suspicions of fraud and standards of business conduct; and a Fraud Action Plan that specifies the action that management should take when fraud is identified or suspected.

It is a fundamental principle that all who are employed in public service, or who hold public office, should act honestly and with integrity to safeguard the public resources for which they are responsible. The risk of fraud or theft poses an ever-present threat to these resources and therefore, ultimately, to the level of patient care that can be provided. The prevention and detection of fraud should be the concern of all members of staff.

DEFINITIONS

Fraud: *the use of deception with the intention of obtaining an advantage, avoiding an obligation or causing loss to another party.*

Corruption: *is the offering, giving, soliciting or acceptance of an inducement or reward which may influence the action of any person.*

Embezzlement: *the felonious appropriation of property by a person to which it has been entrusted.*

Theft: *the dishonest appropriation of the property of another with the intention of permanently depriving them of it.*

NHS GREATER GLASGOW & CLYDE'S POLICY

NHSGGC maintains an honest, open and well-intentioned culture that is committed to the prevention, detection and, ultimately, elimination of any fraud. NHSGGC has systems of internal control and procedures in place that prevent, or reduce the likelihood of, fraud occurring. These include Standing Orders, Standing Financial Instructions, Standards of Business Conduct, operational procedures, fraud guidance and a formal Fraud Action Plan. By these means, NHSGGC ensures that a risk and fraud awareness culture exists throughout the organisation. In addition, all internal control systems are subject to independent review by Internal Audit under the supervision of the Audit Committee.

NHSGGC wishes to encourage anyone having suspicions of theft, dishonesty or fraud to report them to their line manager (or one of the contacts detailed on page 5). A key element of this policy is that members of staff can be confident that they will not suffer in any way as a result of reporting suspicions held in good faith. For these purposes "suspicions held in good faith" shall mean any suspicions other than those that are raised maliciously.

NHS Greater Glasgow & Clyde

Draft Fraud Policy

INVESTIGATION OF FRAUD

This policy has been designed to comply with NHS Circular HDL (2005) 5 “Tackling Fraud in NHS Scotland – Joint Action Programme/Financial Control: Procedure Where Criminal Offences Are Suspected”. NHSGGC is committed to the rigorous and thorough investigation of all cases of fraud or suspected fraud.

NHSGGC has entered into a formal Partnership Agreement with the NHSScotland Counter Fraud Service (CFS), which provides a specialist investigation service to NHSScotland bodies. All instances of fraud, corruption or embezzlement will be referred to CFS for consideration/investigation. Where the CFS conclude that there is prima facie evidence of a criminal offence, then CFS will submit a Standard Prosecution report to the Procurator Fiscal on behalf of NHSGGC

NHSGGC will report instances of theft to the police.

Any decision to take forward a prosecution will be at the sole discretion of the Procurator Fiscal.

NHSGGC will also take appropriate disciplinary action and/or refer the matter to the appropriate professional body in every case where an investigation provides grounds for such action (including instances where there is insufficient evidence to support a referral to the Procurator Fiscal, or no prosecution results after a referral). However, where there is a referral to the fiscal, any internal investigation work or disciplinary action will be carried out in a manner that avoids prejudicing any potential criminal prosecution. All disciplinary action will be taken in accordance with established NHSGGC Human Resource Policies and Procedures

Irrespective of the outcome of the criminal prosecution process, NHSGGC will seek restitution of any losses suffered.

ROLES AND RESPONSIBILITIES

NHSGGC through the Chief Executive, as Accountable Officer, is responsible for:

1. developing and maintaining effective controls to prevent fraud;
2. carrying out vigorous and prompt investigations where fraud occurs and is brought to its attention;
3. taking appropriate legal and/or disciplinary action against perpetrators of fraud;
4. taking disciplinary action against supervisors where supervisory failures have contributed to the commission of the fraud

NHS Greater Glasgow & Clyde

Draft Fraud Policy

Managers are responsible for:

1. identifying the risks to which systems and procedures are exposed;
2. developing and maintaining effective controls to prevent and detect fraud
3. ensuring that controls are being complied with.
4. investigating, and reporting to the police, instances of theft
5. Reporting all instances of Fraud (including theft) to the Fraud Liaison Officer.

Individual members of staff are responsible for;

1. acting in accordance with NHSGGC's Standards of Business Conduct.
2. acting with propriety in the use of official resources and in the handling and use of public funds whether they are involved with cash or payments systems, receipts or dealing with contractors or suppliers;
3. reporting details immediately to (their line manager or one of the contacts below) if they suspect that a fraud has been committed or see any suspicious acts or events.

The Director of Finance is, on behalf of the Chief Executive, responsible for:

1. Issuing a Fraud Action Plan that is consistent with the Partnership Agreement with CFS and details the action to be taken by management when fraud is identified or suspected.
2. Ensuring that all instances of fraud are investigated in accordance with the Fraud Action Plan and the Partnership Agreement with CFS.
3. Keeping the Chief Executive advised of any significant fraud issues.
4. Notifying the Appointed Auditor and Scottish Executive Health Department of Fraud issues when appropriate.
5. Nominating a Fraud Liaison Officer (FLO) who will:
 - Act as a point of contact with CFS.
 - Receive enquiries relating to fraud (confidentially and/or anonymously) on behalf of the Director of Finance
 - Co-ordinate any fraud investigation
 - Keep the Director of Finance apprised of all issues relating to fraud.
 - Support the Director of Finance in the discharge of his responsibilities under the Fraud Policy.

NHS Greater Glasgow & Clyde

Draft Fraud Policy

The Director of Human Resources will ensure that those involved in the investigations are advised in matters of employment law and in other procedural matters, such as disciplinary and complaints procedures, as required.

NHS Greater Glasgow & Clyde

Draft Fraud Policy

REPORTING FRAUD

Any staff member with evidence or suspicions of fraud should report the matter immediately to their line manager. Time may be of the utmost importance to ensure that NHSGGC does not continue to suffer a loss. Staff should be assured that there will be no recriminations against staff who report suspicions held in good faith. Victimising or deterring staff from reporting concerns is a serious disciplinary matter. Any contravention of this policy should be reported to the Chief Executive. Equally however, abuse of the process by raising malicious allegations could be regarded as a disciplinary matter.

Anyone who suspects their manager of involvement in fraud has a choice of:

- Going to the next more senior person in the department or directorate
- Reporting the matter directly to the Director of Finance
- Discussing the matter confidentially and/or anonymously with the Fraud Liaison Officer
- Reporting the matter via the NHS Counter Fraud service Hotline

Anyone concerned about speaking to another member of staff could ask for advice first from the charity “Public Concern at Work” telephone 0171 404 6609. They can provide independent and confidential advice.

Your cooperation in this matter is appreciated. Relevant contact points are as follows:

Director of Finance	0141 201 4609
Fraud Liaison Officer	0141 201 4771
Chief Executive	0141 201 4641
NHS Counter Fraud Service Hotline	08000 15 16 28



DRAFT ONLY.
For Final Approval

Risk Management Strategy

NHS GREATER GLASGOW & CLYDE	Custodian: Head of Clinical Governance
Issue date: N/A - version at feb 07	Status: for final approval
Version: 0.7	Review Interval: Two years

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2. What is the purpose of the Risk Management Strategy?
3. What do we want the strategy to achieve?
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5. What is our approach to risk management?

Glossary of Terms

Assurance. Stakeholder confidence in our service gained from evidence showing that risk is well managed.

Corporate Risk Register. A Board level register, which spans all units on a Pan-Board basis.

Healthcare Governance. The system by which NHS Greater Glasgow & Clyde is directed and internally controlled to achieve objectives and meet the necessary standards of accountability, probity and openness in all three areas of clinical, corporate and staff governance.

Internal Control. Corporate governance arrangements designed to manage the risk of failure to meet NHS Greater Glasgow & Clyde's objectives.

Likelihood. Chance of circumstances in question actually occurring.

Near Miss. An undesirable incident that by chance or design did not result in harm or loss.

Incident. An adverse event which causes or may have caused physical or psychological harm.

Incident Recording. The system of reporting adverse events or near misses.

Partnership. Way of working where staff at all levels and their representatives are involved in developing and putting into practice the decisions and policies which affect their working lives.

Risk. The likelihood, high or low, that somebody or something will be harmed by an unwanted event or incident, multiplied by the severity of the potential harm. Risks are measured in terms of their likelihood and consequences.

Risk Assessment. The systematic process to identifying risk and evaluating their potential likelihood and consequences.

Risk Control Measure. Something done to minimise risk to an acceptable level either by reducing the likelihood of an adverse event or the severity of its consequences or both.

Risk Register. A database of risks. Always changing to reflect the dynamic nature of our risks and our management of them. Its purpose is to help managers prioritise available resources to minimise risk to best effect and provide assurances that progress is being made.

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 Management Principles. Ideology for the implementation of risk management.

Risk Management. The culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects.

Root Cause Analysis. Structured techniques to establish the true systematic causes of an event as opposed to its apparent causes.

Significant Risk. Broadly, any risk that could adversely affect achievement of NHS Greater Glasgow & Clyde's objectives or present a large loss with no clear opportunity for control.

Statement of Internal Control. A statement by the accountable officer within the published Annual Report, required by HDL(2002)11, on the effectiveness of NHS Greater Glasgow & Clyde's systems of internal control, for which risk management is a key component.

1. Why is Risk Management so important to us?

NHS Greater Glasgow & Clyde aims to provide high quality and safe services to the public it serves in an environment which is also safe for the staff it employs or contracts with to provide services.

In fulfilling this aim, NHS Greater Glasgow & Clyde will establish a robust and effective framework for the management of risk, one that is proactive in understanding risk, builds upon existing good practice and is integral to all our decision making, planning, performance reporting and delivery processes.

The strategy is predicated on the belief that Risk Management is:

- **An important activity to ensure the health / well being of patients, staff and visitors.**
- **An inclusive and integrative process covering all risks, set against a common set of principles.**
- **Best implemented where good practice is acknowledged and built upon.**
- **A major corporate responsibility requiring strong leadership and regular review.**

We believe that the provision of high standards of health, safety and welfare within a risk management framework is fundamental to the provision of high standards of health care.

To fulfil this requirement we will:

- Develop a culture, which secures the involvement and participation of all - staff, patients and the public - in risk assessment and incident reporting.
- Implement measures to systematically identify and control risk as an effective approach to the prevention of injury, ill health and loss.
- Secure the commitment of management at all levels to promote risk management and provide the necessary leadership and direction.
- Adopt common standards throughout NHS Greater Glasgow & Clyde to provide and maintain robust systems to ensure compliance with relevant statutory requirements.
- Monitor and review risk management performance at all levels against agreed standards to ensure that corrective action is taken where necessary.
- Ensure that there are processes to facilitate the systematic recording and reporting of incidents and 'near misses' to minimise the risk of recurrence. The reporting mechanism will focus on systems more than individuals and cover clinical and non-clinical incidents.
- Recognise the contribution of all key stakeholders, including patients and the public, to ensure their involvement and participation in the overall risk management process.
- Have in place effective systems of communication to ensure the dissemination of information on risk management matters across NHS Greater Glasgow & Clyde.
- Secure the provision of resources, facilities, information, training, instruction and supervision to meet these objectives.

2. What is the Purpose of the Risk Management Strategy?

NHS Greater Glasgow & Clyde recognises the success of different arrangements developed for managing risk over the last few years in each of the predecessor Trusts and aims to build on the existing framework in existence at a Divisional level and develop a common set of standards and principles to underpin risk management across the single system.

This strategy thus affirms NHS Greater Glasgow & Clyde's commitment to improve its capability to manage risk. By tackling risk in the systematic way described in this strategy we can drive continuous improvement and have a positive impact on the quality of care, our staff and the efficiency of NHS Greater Glasgow & Clyde.

This strategy also formalises risk management responsibilities and sets out how the public may be assured that our risks are managed effectively and accordingly, represents a major element of NHS Greater Glasgow & Clyde 's healthcare governance arrangements.

The following principles underpin our approach to risk management in NHS Greater Glasgow & Clyde.

Table 1: Guiding Risk Management Principles

1. Founded on adopting a pan Health Board approach
2. Incorporates clinical and non clinical risk
3. Is comprehensive and integrated
4. Supported by clear processes for escalation of risk
5. Only exceptional risks advance to the Corporate Register
6. Integral to the business agenda and informs performance review
7. Provides assurance that effective systems are in place

3. What do we want the Strategy to Achieve?

The overall goal of risk management is to have an environment of 'No Surprises' where we understand the risks we face and eliminate or control them to an acceptable level, by creating a culture founded upon assessment and prevention of risk. To realise this goal, this strategy seeks to achieve the following objectives.

Table 2: Key Strategic Risk Management Objectives

It is our aim that the effective management of risk within a common set of agreed principles will

1. Be integral to all our decision making, planning, performance reporting and delivery processes.
2. Be devolved to Division/Directorates/Partnerships within a supportive common framework.
3. Improve the quality of patient care by preventing or reducing harm or potential harm to patients.
4. Minimise liabilities in the event of harm to a patient, visitor or member of staff.
5. Improve the safety and quality of the working environment for the benefit of all staff
6. Ensure stakeholders are kept informed of the developing Risk Management process.

4. Responsibilities

4.1 Overall Organisational Arrangements

Governance

The **Board** is a board of governance and is corporately responsible for NHS Greater Glasgow & Clyde's 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 in NHS Greater Glasgow & Clyde—principally these are the **Performance Review, Audit, Staff and Clinical Governance Committees**. Their respective risk management roles are described in the diagram in section 4.5 below.

In addition each Division, Directorates, Partnerships and other significant service groups within NHS GG&C organisational structure will, individually and through their support to the Risk Management Steering Group, regularly review the Risk Management arrangements to give assurance/status reports to the Board and its formal committees.

The combination of these arrangements will ensure that from a governance perspective there is a clear focus on both the corporate and risk management processes the Acute Services Division and Partnership organisations.

Executive and Divisional Management

Whilst the Chief Executive has overall accountability for risk management across NHS Greater Glasgow & Clyde, the general management arrangements are tasked with the unambiguous lead role to co-ordinate, integrate, oversee and support the risk management agenda and provide assurances to the Board (and its Committees) that all significant risks are adequately managed and the risk management principles are embedded across NHS Greater Glasgow & Clyde.

It will be the responsibility of each Director, and their senior Management Team, to implement local arrangements, which accord with the principles, and objectives set out in this strategy.

To support the General Management arrangements in the development of risk management arrangements within NHS Greater Glasgow & Clyde, a Risk Management Steering Group has been established to provide technical and professional advice, which reports to the Chief Executive.

4.2 Roles and Responsibilities

All members of the Management Teams will have risk management responsibilities defined in their job descriptions and personal objectives. This will include the identification, assessment and analysis of risks and action plans to eliminate or minimise the impact of known risks.

Within each Management Team individuals may also be nominated to lead and co-ordinate particular elements of the risk management process and to work with colleagues and the local risk management advisors to develop and implement agreed actions.

All managers across NHS Greater Glasgow & Clyde have a responsibility to ensure that their staff are familiar with the latest risk management guidance and controls.

4.2 Roles and Responsibilities (continued)

All staff have a part to play, particularly in identifying and assessing risk. Staff will be actively encouraged to report all incidents, including 'near misses'. In order to ensure full reporting of incidents, a 'just culture' will be operated within which staff are free to report on incidents and concerns in the knowledge that they will be supported.

The delivery of NHS Greater Glasgow & Clyde's objectives increasingly relies upon effective co-operation, partnerships and joint working with partner agencies such as Local Authorities, Universities and the Voluntary Sector and independent contractors such as GP's, Dentists, Community Pharmacists and Opticians. NHS Greater Glasgow & Clyde commits to minimise any risk by ensuring:

- All areas will manage risk in partnership with partner agencies and contractors;
- An adequate risk management framework is incorporated as part of the governance arrangements for joint management and partnership agreements;
- Common objectives are agreed with partner agencies, contractors and the voluntary sector.

4.3 Learning and Development

To implement this strategy, focused and effective learning and development interventions are essential to achieve:

- A workforce with the competence and capacity to manage risk and handle risk judgements with confidence
- An organisational focus on identifying malfunctioning systems rather than people
- Organisational learning from adverse events.

Accordingly, plans will continue to be developed to promote risk management learning and development across NHS Greater Glasgow & Clyde.

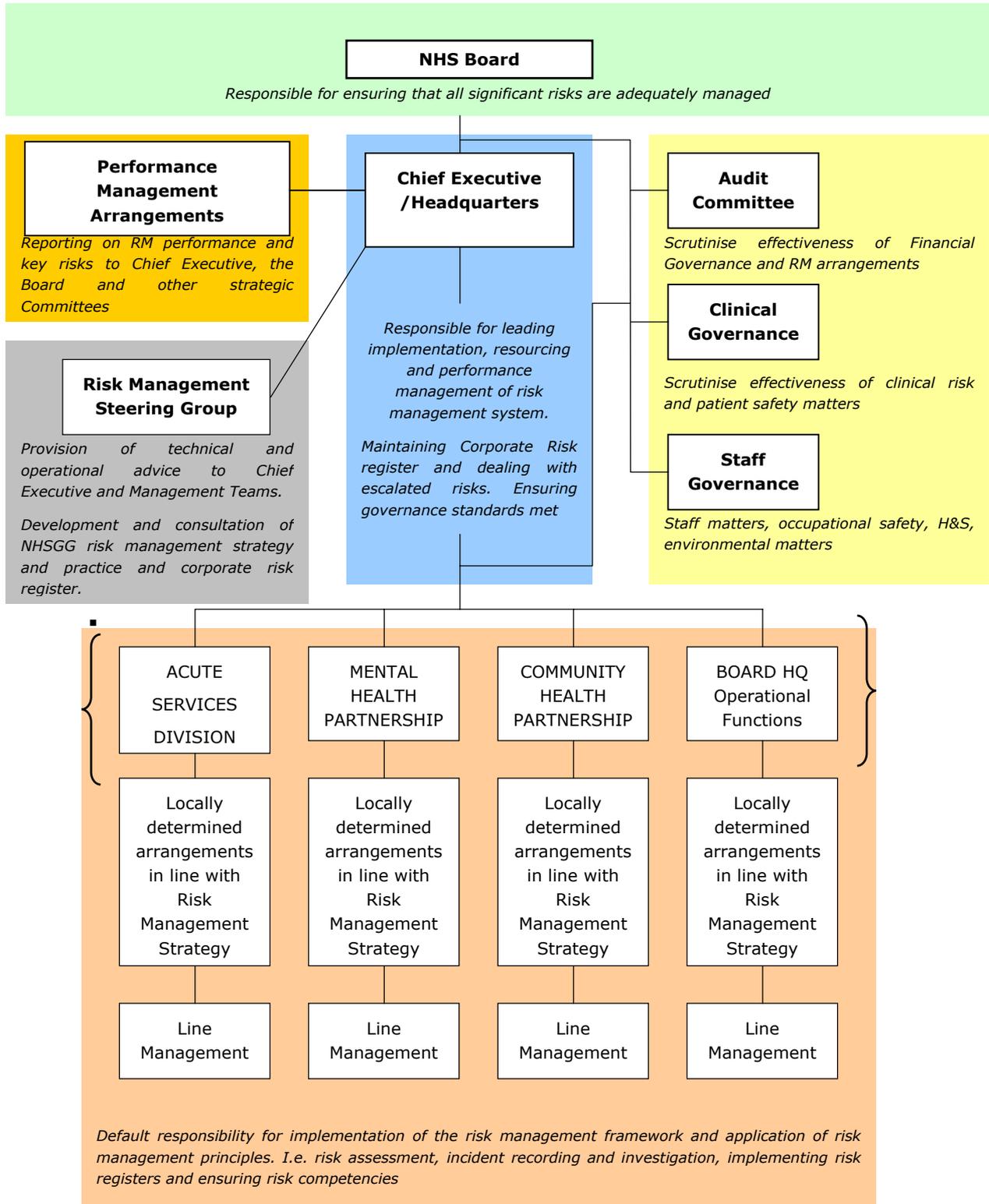
4.4 Provision of Support and Information

The availability of timely and accurate risk information is necessary for the implementation of this strategy. Accordingly, NHS Greater Glasgow & Clyde will:

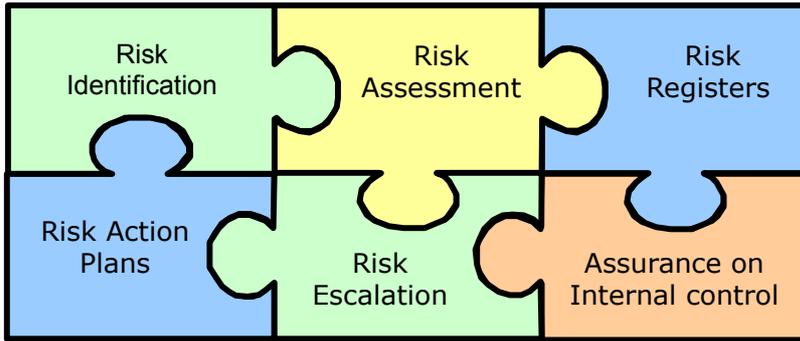
- Support the development of systems to support risk assessment, identification and the sharing of lessons as an integral part of performance monitoring;
- Develop relevant policy and guidance and ensure that it is kept up to date and remains easily accessible;
- Put in place effective systems of communication to make sure everyone in the organisation is sufficiently informed about risk management;

Promote continuous improvement and the sharing of good practice.

4.5 Schematic of Reporting Structure and Responsibilities



5. What is our Approach to Risk Management?



NHS Greater Glasgow & Clyde is a large, diverse and complex organisation where our Management Teams and staff already manage risk as an integral part of what they do every day. A universal prescriptive method to manage risk would therefore be

inappropriate. Instead, Divisional Management Teams managing risk in a way that best suits their existing style and arrangements should be able to demonstrate that they are managing risk in a consistent manner through the adoption of the guiding principles and general approach described in this strategy. This will ensure that common standards for the management of risk apply across NHS Greater Glasgow & Clyde and support the assurance and business requirements of the NHS Greater Glasgow & Clyde Board and its corporate management. The key components of the risk management framework are noted below:

5.1 Risk Identification



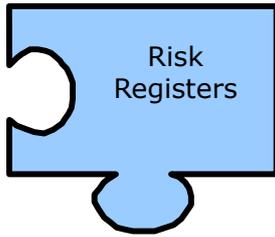
NHS Greater Glasgow & Clyde aims to minimise the likelihood and severity of risk events by the recording of all incidents or near misses through Incident Recording systems. It is the responsibility of management to encourage staff to report incidents that could pose a hazard or threat to people or the provision of services and thus enable improvements to be identified, prioritised and implemented. Recording and analysis processes will be available to support local data entry, with the overall aim of shared learning across NHS Greater Glasgow & Clyde. In addition to risks identified through the Incident Recording systems the Directors and the Management Teams will also be required to regularly 'horizon scan' to identify risks by looking forward to tomorrow's threats as part of the development of their Risk Register.

5.2 Risk Assessment



All risks shall be assessed using a standard classification matrix which will be applied consistently across NHS Greater Glasgow & Clyde. This will involve the assessment of risk in terms of the consequences and the likelihood of occurrence.

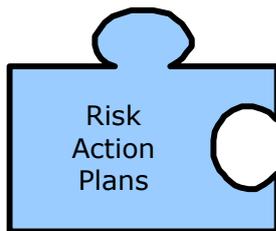
5.3 Risk Registers



Each Division, Directorate or Partnership will be responsible for maintaining its own **Risk Register**. The risk register will be used by each Management Team to inform priorities for the local implementation and monitoring of agreed mitigating controls. Each risk will be allocated a risk owner(s) who will be responsible for taking appropriate action to minimise its impact. Review of the risk register will be a standing Management Team agenda item that will help inform planning, management decisions and priorities. Management Teams will be expected to regularly review and update their risk registers.

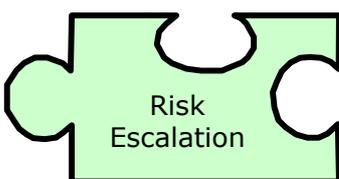
The NHS Greater Glasgow & Clyde corporate management will be responsible for maintaining a **Corporate Risk Register** which will record and report on action being taken to manage the strategic risks facing NHS Greater Glasgow & Clyde. The risks included on the Corporate Risk Register will be informed by the escalation procedures noted below, as well the collective input of Headquarters and the NHS Greater Glasgow & Clyde Board.

5.4 Risk Action Plans



All risks identified and prioritised for action within the Risk Register will require a supporting action plan, which will ensure that the risk is managed to an acceptable level. It will be the responsibility of the Management Teams and Headquarters to determine the most appropriate form of action and to allocate responsibility for implementation to an appropriate individual(s).

5.5 Risk escalation



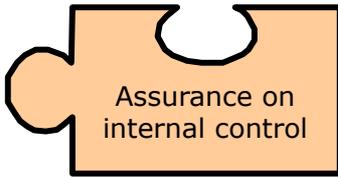
If significant risks have been identified that are deemed impossible or impractical to manage at a local Management Team level, then they should be reported for review by the Director, or COO, for reporting to Headquarters. Assessment and improvement should then be monitored through inclusion in the NHS Greater Glasgow & Clyde Corporate Risk register.

In the absence of such escalation, the responsibility for the management of risks remains with the Management Teams. Within Directorates or Partnerships similar escalation arrangements will be implemented to ensure that significant risks are highlighted for inclusion within local Risk Registers where this is deemed appropriate.

Table 3: Nature of Risks which may need to be Escalated

- Significant threat to achievement of health plan objectives or targets
- Assessed to be a substantial or intolerable risk
- Widespread beyond local area
- Significant cost of control far beyond the scope of budget holders
- Potential for significant adverse publicity

5.6 Assurance on the Effectiveness of Key Controls



As a result of the devolved accountability for all operational matters within NHS Greater Glasgow & Clyde, the Board requires assurance that local systems are capable of identifying their objectives and managing the risk to their achievement. To assist the Board meet its governance requirements in respect of the management of risk, the Management Team's will assess the effectiveness of the risk management processes and link to the Risk Management Steering Group to provide assurance to the NHS Greater Glasgow & Clyde Audit, Staff and Clinical Governance Committees.

The Chief Executive and  Performance Review Group will evaluate assurances for the most significant and widespread risks contained within the NHS Greater Glasgow & Clyde corporate risk register and regularly report their findings to the Board. This would include a view on NHS Greater Glasgow's ability to meet its objectives. This will ensure that risk management becomes firmly embedded as a Board responsibility and that assurances can be provided at all levels on the overall effectiveness of the risk management processes across NHS Greater Glasgow.

To provide confidence to patients, staff and the public that this is the case, NHS Greater Glasgow & Clyde will publish within it's annual financial accounts a Statement of Internal Control commenting on the effectiveness of the risk management arrangements.

AUDIT COMMITTEE**OBJECTIVES**

The purpose of the Audit Committee is to assist the Board to deliver its responsibilities for the conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide assurance to the Board that an appropriate system of internal control is in place to ensure that:

- ◆ business is conducted in accordance with law and proper standards governing the NHS and its interface with partner organisations;
- ◆ public money is safeguarded and properly accounted for;
- ◆ financial Statements are prepared timeously, and give a true and fair view of the financial position of the Board for the period in question; and
- ◆ reasonable steps are taken to prevent and detect fraud and other irregularities.

MEMBERSHIP AND CONDUCT OF BUSINESS

The Committee membership shall be appointed by the full Board and given a remit, including providing advice to the Board on the conduct of its business.

The Board shall nominate up to nine Non-executive Members. A Convener will be appointed from the Membership of the Committee. The Chair of the Board shall not be a member of the Committee but shall have the right to attend meetings. As the Committee is responsible for overseeing the regularity of expenditure by NHS Greater Glasgow, other Board Members shall also have the right to attend.

At least three members of the Committee must be present in order to form a quorum.

The Head of Board Administration (or authorised nominee) shall perform the function of Secretary to the Committee.

The Committee shall be able to require the attendance of any Director or member of staff.

The external auditor, internal auditor and Director of Finance shall normally attend all meetings.

The external auditor and internal auditor shall be offered the opportunity to hold discussions with the Committee without the Director of Finance, other Executive Directors or Board staff being present.

There will be a minimum of ~~six~~ **four** meetings per annum with provision for additional meetings as required.

The minutes of meetings will be submitted to the Board. The Committee Convener will also make a formal report to the Board on a regular basis/at least annually covering the activities of the Committee and any significant matters of note. Minutes will be publicly available.

REMIT

The Committee shall be responsible for monitoring the Board's corporate governance arrangements and system of internal control. This will include the following specific responsibilities.

AUDIT COMMITTEE**(i) Corporate Governance, System of Internal Control, Risk Management and Arrangements for the Prevention and Detection of Fraud**

1. Overseeing the Board's Governance arrangements, including compliance with the law, SEHD guidance or instructions, the Board's Standing Orders and Standing Financial Instructions and Code of Conduct.
2. Evaluating the adequacy and effectiveness of the internal control environment and providing a statement annually to the Board, based on the annual report of the Internal Auditors and other appropriate sources of assurance.
3. Reviewing the assurances given in the Statement on Internal Control.
4. Critically reviewing the process by which management decisions are taken and effected throughout the Health Board, including risk assessment.
5. Monitoring the effectiveness of arrangements to manage risk and prevent and detect fraud.

(ii) Standing Orders, Standing Financial Instructions and Other Governance Documentation

1. As required but at least annually, reviewing changes to the Standing Orders, Standing Financial Instructions and other governance documentation including the Fraud Policy and Standards of Business Conduct and recommend changes for Board approval.
2. Reviewing annually (or as required) the Scheme of Delegation.
3. Examining circumstances when the Board's Standing Orders and Standing Financial Instructions are waived.

(iii) Internal and External Audit

1. Approving the arrangements for securing an internal audit service,
2. Reviewing the operational effectiveness of internal audit and the annual performance of external audit.
3. Approving and reviewing internal and external audit plans, and receive reports on their subsequent achievement.
4. Monitoring management's response to audit recommendations, and report to the Board where necessary.
5. Receiving management letters and reports from the statutory external auditor, and reviewing management's response.
6. Discussing with the external auditor (in the absence of the Executive Directors and other officers where necessary) the annual report, audit scope and any reservations or matters of concern which the external auditor may wish to discuss.
7. Ensuring that the Chief Internal Auditor and External Auditor have unrestricted access to the Chairman of the Committee.

AUDIT COMMITTEE

8. Ensuring co-ordination between internal and external audit.
9. **Receiving and approving the internal auditors' report on the review of property transactions monitoring and reporting the results of this review on behalf of the NHS Board to the Scottish Executive in accordance with the NHS Scotland Property Transactions Handbook.**

(iv) Annual Accounts

1. Approving changes to accounting policies, and reviewing the Board's Annual Accounts prior to their adoption by the full Board. This includes:
 - reviewing significant financial reporting issues and judgements made in the preparation of the Annual Accounts;
 - reporting in the Directors' report on the role and responsibilities of the Audit Committee and the actions taken to discharge those;
 - reviewing unadjusted errors arising from the external audit; and
 - reviewing the schedules of losses and compensations.

1. The Convener of the Audit Committee (or appointed Deputy) should be in attendance at the Board meeting at which the Annual Accounts are approved.

Support Arrangements

The Chief Executive shall be responsible for implementing appropriate arrangements within the organisation to support the effective operation of the Audit Committee. These arrangements shall be subject to approval by the Audit Committee and shall ensure that assurances can be provided to the Audit Committee that reports and recommendations are being actioned at a local level by management. These arrangements shall be subject to review and evaluation on an annual basis by the Committee.

April 2007

NHS GREATER GLASGOW AND CLYDE

CLINICAL GOVERNANCE COMMITTEE

1. Objectives

The purpose of the Clinical Governance Committee is to assist the NHS Board to deliver its statutory responsibility for the quality of healthcare that it provides. In particular, the Committee will seek to provide assurance to the Board that an appropriate system for monitoring and development is in place, which ensures that clinical governance and clinical risk management arrangements are working effectively to safeguard and improve the quality of clinical care. This includes affirming that NHS Greater Glasgow and Clyde

- has established clear lines of responsibility and accountability for the overall quality of care that it provides or commissions
- has in place a soundly based clinical governance framework including strategy and local development plans
- has in place reporting arrangements which ensure that the Board and Clinical Governance Committee are fully informed on the development of clinical governance
- is taking all reasonable steps to prevent, detect and rectify irregularities or deficiencies in the quality of care provided or in the clinical governance framework
- is doing its reasonable best to meet its objectives of improving health and tackling inequalities whilst protecting patients, staff, the public and other stakeholders against risks of all kinds.

2. Membership And Conduct Of Business

The membership and remit of the Committee shall be approved by the full Board. The Committee shall comprise:

Chair

Deputy Chair

8 Non Executive Board Members (to include the Employee Director and 1 from Clyde)

2 Lay Members (to include 1 from Clyde)

The Chair and Deputy Chair of the Committee will be designated by the Chairman of the Board. At least three voting members of the Committee must be present in order to form a quorum. There will be a minimum of six meetings per annum with provision for additional meetings as required.

In order to bring together the professional support required for the Committee to perform its functions the Board Medical Director, Director of Nursing, Director of Public Health, Infection Control Manager, Head of Clinical Governance and a Consultant in Public Health Medical from Clyde. shall be ex-officio Members of the Committee (without voting rights). The Committee shall be able to require the attendance of any Director or member of staff. The Chief Executive shall have the right to attend meetings.

The minutes of meetings will go to the Board and will be made publicly available. In addition to any specific reports the Committee Chairman will also provide to the Board a formal annual report and a controls assurance statement covering the performance and development of the Clinical Governance Framework. The Head of Board Administration (or authorised nominee) shall perform the function of Secretary to the Committee.

3. Remit

The Clinical Governance Committee should provide an independent judgement on how the Board as a whole is managing the issues of strategy, performance and stewardship of public resources as they relate to the safety and quality of clinical care.

The Clinical Governance Committee will operate as necessary in order that it is confident that clinical governance and clinical risk management arrangements are working effectively to safeguard and improve the quality of clinical care. This will include

- endorsing the clinical governance strategy and development plan prior to approval from the NHS Board
- critically reviewing information from services or functions of clinical governance
- critically reviewing reports and action plans arising from the work of internal audit, external audit, review agencies and inspectorates as they relate to the assurance on the effectiveness of clinical risk management and quality improvement
- requiring the presentation of reports, including the commissioning of independent reviews, in order to supplement or validate information
- being actively involved in strategy formulation from the earliest stages
- making judgements about, and helping to regulate, the scale and pace of change that takes account of the organisation's capacity and the need to minimize bureaucracy
- ensuring there is evidence of openness and transparency in decisions and use of resources in providing good quality of care
- striving for public good, setting aside personal interests, and ensuring NHS Greater Glasgow is improving health and tackling inequalities
- promoting good relationships within the organisation, with the public and service users and with other organisations.

April 2007

NHS GREATER GLASGOW AND CLYDE

STAFF GOVERNANCE COMMITTEE

1. Objectives

- 1.1 The purpose of the Staff Governance Committee is to provide assurance to the Board that NHS Greater Glasgow and Clyde meets its obligations in relation to staff governance under the National Health Service Reform (Scotland) Act 2004 and the Staff Governance Standard.
- 1.2 In particular, the Committee will seek to ensure that staff governance mechanisms are in place that take responsibility for performance against the Staff Governance Standard and are accountable for progress towards achievement of the Standard.

2. Membership and Conduct of Business

- 2.1 The Committee membership shall be appointed by the NHS Board and given a remit, including providing advice to the Board on the conduct of its business.
- 2.2 The Board shall nominate the membership from the Non-Executive Directors of the NHS Board to include the Chair of the Board and the Employee Director. The Committee will be co-chaired by the Employee Director and a Non-Executive Director appointed by the Board from the membership of the Committee.
- 2.3 At least three Members of the Committee must be present in order to form a quorum.
- 2.4 Members of the Area Partnership Forum listed below shall be ex-officio Members of the Committee (without voting rights):
 - Director of Human Resources
 - Associate Director of Human Resources (Acute)
 - Associate Director of Human Resources (Partnerships)
 - Director (representing CHCPs)
 - Director (representing Acute)
 - Areas Partnership Forum Staff Side Secretaries (2)
 - Area Partnership Forum Acute Division Joint Trade Union representative
 - Area Partnership Forum CH(C)Ps Joint Trade Union representative
 - Area Partnership Forum Mental Health Partnership Joint Trade Union representative.

The Committee may invite to attend other senior managers and trade union representatives.

- 2.5 The Head of Board Administration shall provide secretariat support.
- 2.6 There should be a maximum of four meetings per annum with provision for additional meetings as required.
- 2.7 The minutes of meetings will be submitted to the Board. A Joint Chair of the Committee will also make a formal report to the Board on a regular basis, at least annually, covering the activities of the Committee and any significant matters of note.

3. Remit

- 3.1 The Committee shall support the creation of a culture within the health system, where the delivery of the highest possible standards of staff management is understood to be the responsibility of everyone working within NHS Greater Glasgow and Clyde and this is built upon partnership and co-operation.

- 3.2 The Committee shall act for the Board in ensuring that structures and processes to ensure staff are:
- Well informed
 - Appropriately trained
 - Involved in decisions which affect them
 - Treated fairly and consistently
 - Provided with an improved and safe working environment.
- 3.3 The Committee shall monitor and evaluate progress through the approval of local human resource strategies and implementation plans.
- 3.4 The Committee shall be authorised by the Board to support any policy amendment, funding or resource submission to achieve the Staff Governance Standard.
- 3.5 The Committee shall be responsible for the timely submission of all the staff governance data required as part of the Accountability Review.
- 3.6 The Remuneration Subcommittee will be a subcommittee of the Staff Governance Committee and will consider the remuneration of the Executive Directors and other staff employed under the Executive Pay arrangements.

June 2006

NHS GREATER GLASGOW AND CLYDE

PERFORMANCE REVIEW GROUP**1. Objectives**

The Performance Review Group carries delegated responsibility with powers on behalf of the NHS Board for:

Monitoring and progressing -

- i) organisational performance;
- ii) resource allocation and utilisation;
- iii) implementation of agreed NHS Board strategies.

2. RemitOrganisational Performance

- i) Maintaining an overview of NHS Board performance.
- ii) Ensuring a co-ordinated approach to the management of performance improvement across all aspects of the Board's responsibilities, activities and partnerships consistent with the Board's corporate objectives and priorities.
- iii) Ensuring consistency in arrangements for performance scrutiny, accountability and reporting across the Board recognising the existing responsibilities of the Governance Committees and, in particular, the Staff Governance Committee and Clinical Governance Committee
- iv) Reviewing preparation and implementation of the NHS Board's Local Delivery Plan.
- v) Monitoring and scrutinising progress against key national and local performance targets.
- vi) Overseeing preparations for and actions arising from the NHS Board's Annual Review with the Minister for Health and Community Care.

Monitoring of Resource Allocation and Utilisation

- i) Reviewing and submitting to the NHS Board for approval the 5-year financial strategy as an integral part of the local delivery plan/health planning process.
- ii) Considering and providing advice to the NHS Board on annual financial allocations and investment plans as part of the Local Delivery Plan.
- iii) Monitoring in-year financial performance across NHS Greater Glasgow and Clyde.
- iv) Providing recommendations to the NHS Board on the annual Capital Plan.
- v) Carrying delegated authority from the NHS Board for individual schemes within the approved Capital Plan as follows:

- a) Approval of individual schemes covering the value of £1.5M - £5M – a short business case would be required to be submitted for approval.
 - b) Approval of individual schemes covering the value of £5M - £10M – a business case would be required to be submitted for approval.
 - c) Approval of individual IM&T Schemes covering the value of £500,000 - £1M – a business case would be required to be submitted for approval.
 - d) Approval of individual IM&T Schemes covering the value over £1M – Divisions required to submit a business case for approval.
- vi) Monitoring the annual capital expenditure programme.

Monitoring of the Implementation of NHS Board Agreed Strategies

- i) Approving key stages of implementing agreed NHS Board strategies where business cases are to be submitted to SEHD for approval, including:
 - a) approving key investment decisions including those affecting the procurement stages of implementing the Acute Services Strategy;
 - b) approving outline business cases;
 - c) approving full business cases;
 - d) approving the performance framework and accompanying management scrutiny and reporting arrangements

with full reports to the NHS Board on significant stages.
- ii) Monitoring the implementation of NHS Board approved strategies in relation to meeting key milestones, timescales, approved expenditure limits and overall governance of the relevant strategy.
- iii) Approving land and property transactions relating to the disposal and acquisition of property.

3. Composition

- i) The Performance Review Group will comprise 9 Non Executive Directors of the NHS Board.
- ii) The Group will normally meet on a 2-monthly cycle and more frequently, if required. All NHS Board Members will receive a copy of the papers in advance of the meeting to allow those who are not members of the Performance Review Group to feed in thoughts/comments to the Chair/Officers of the NHS Board.
- iii) All NHS Board Members will have the right to attend and participate in discussions at the Performance Review Group meetings.
- iv) The Group will request the attendance of those officers of the NHS Board it requires in order to conduct its business effectively and efficiently.
- v) The quorum for meetings of the Group shall be one-third of the membership.

- vi) The Chair and Vice-Chair of the NHS Board and Chief Executive have delegated responsibility to collectively deal with urgent matters between meetings which are covered by the Performance Review Group remit and to report to the next available meeting such matters dealt with using this delegation and seek the Group's endorsement to the action/decisions taken.
- vii) The Performance Review Group's powers do not take away the responsibilities of the NHS Board for executive action.

4. Reporting Arrangements

The Minutes of the Performance Review Group will be submitted to the NHS Board for information, along with any recommendations as appropriate.

John C Hamilton
March, 2006
3rd Revision

NHS GREATER GLASGOW AND CLYDE**INVOLVING PEOPLE COMMITTEE*****Objectives***

1. To ensure the mainstream integration of the principles of Patient Focus and Public Involvement in planning, delivering and sustaining services.
2. To scrutinise NHS Greater Glasgow and Clyde services on a continuous basis to ensure implementation of best practice in achieving Patient Focus and Public Involvement.
3. Leading the development of a sustainable NHS Greater Glasgow and Clyde Involving People Framework and ensuring that it is delivered via approved strategies and action plans across the totality of service provision.
4. Encouraging and promoting the skills required deliver effective Patient Focus Public Involvement among NHS Staff and patient and local community representatives.
5. To ensure that delivery of Patient Focus Public Involvement across NHS Greater Glasgow and Clyde is co-ordinated, consistent and linked to the work of partner organisations, including Community Planning structures.
6. Reviewing, interpreting and supporting the implementation of national Patient Focus and Public Involvement objectives and priorities at the local level.
7. Driving the development, introduction and maintenance of corporate initiatives and structures to support the effective delivery of Patient Focus and Public Involvement.
8. Promoting dialogue with patients and public regarding progress with Patient Focus and Public Involvement.
9. Linking with the new Scottish Health Council and supporting NHS Greater Glasgow and Clyde's day-to-day relationship with its officers and advisory council members.
10. Facilitating continuous and formal annual accountability and quality assurance reviews as part of the accountability review process.
11. Ensuring the NHS Board is kept fully informed on progress in mainstreaming and delivering PFPI, in part by formally reporting to the Board on a quarterly basis.

Composition

1. The Committee shall comprise 7 non-executive Members from Greater Glasgow and Clyde NHS Board, a representative of the Employee Director of the NHS Board, the Director of Communications for NHS Greater Glasgow and Clyde (the 'Designated Director' for Patient Focus and Public Involvement in NHS Greater Glasgow), a representative from the Area Clinical Forum, a representative of the Glasgow Council for the Voluntary Sector and shall have the power to co-opt up to four Lay Members from outwith the Membership of Greater Glasgow and Clyde NHS Board.
2. Executive Members of the Board and senior management and clinical staff will be invited to attend meetings with regard to specific agenda items.
3. The quorum of meetings of the Involving People Committee shall be 4 voting Members.

Remit

Greater Glasgow and Clyde Wide

1. To ensure that NHS Greater Glasgow and Clyde discharges its legal obligations to involve, engage and consult patients, the public and communities in the planning and development of services and in decision-making about the future pattern of services.

GGCNHS Board Staff

2. The Committee will be responsible for oversight of all staff employed by the Board.
3. The Committee shall oversee the preparation and delivery of PFPI-related performance plans within the context of service delivery by Board clinical, managerial and support staff prepared on a Departmental and Service basis and critically review these plans annually.

Frequency

The Committee will meet 6 times a year.

Reporting Arrangements

The Committee shall report its proceedings to the Board, by the submission of the Minutes of meetings and ad hoc papers.

April 2007

NHS GREATER GLASGOW AND CLYDE
RESEARCH ETHICS GOVERNANCE COMMITTEE

Constitution

1. Terms of Reference

The NHS Greater Glasgow and Clyde Research Ethics Governance Committee is appointed by Greater Glasgow and Clyde NHS Board to oversee all of the Board's responsibilities for the establishment, support, training and monitoring of all NHS Local Research Ethics Committees (LRECS) within its geographical boundary as defined in Scottish Executive Health Department Governance Arrangements for NHS Research Ethics Committees in Scotland (2001) and any subsequent Guidance issued.

The Committee shall oversee and monitor the functions of the Local Research Ethics Committees within NHS Greater Glasgow and Clyde with a view to leading to the harmonisation of procedures and the formation of a common set of criteria for considering ethical applications.

2. Functions

The Committee shall be responsible for the oversight of all matters pertaining to the proper functioning of all Local Research Ethics Committees in Greater Glasgow and Clyde.

The Committee shall act for the Board in ensuring that its Local Research Ethics Committees are provided with the requisite training and education required to undertake their functions effectively.

The Committee shall act for the Board in ensuring that Members of all Local Research Ethics Committees in Greater Glasgow and Clyde are properly indemnified in the discharge of their duties.

The Committee shall receive from all Local Research Ethics Committees in Greater Glasgow and Clyde annual reports and these Local Research Ethics Committees shall report to the NHS Greater Glasgow and Clyde Ethics Committee any issues requiring its attention.

The Committee shall be a central repository for reports and good practice and advise all Local Research Ethics Committees in Greater Glasgow and Clyde of identified unethical practice etc.

3. Membership

Membership of the Committee shall consist of four Non-Executive Members of the Board, one of whom shall act as its Chair, the Board's Director of Public Health and the Board's Medical Director. The Director of Public Health and the Medical Director should name a deputy to act on their behalf should it prove impossible for them to attend a meeting.

The Committee shall have the power to co-opt or invite attendance of any person whom it considers to be of assistance in its deliberations.

4. Quorum

The quorum for meetings of the Committee shall be the Chair or designated deputy and two other Members.

5. Number of Meetings

The Committee shall meet at least twice per annum.

6. Administrative Arrangements

The Head of Board Administration (or authorised nominee) shall undertake the functions of Secretary to the Committee.

7. Standing Orders

The Board's Standing Orders, so far as applicable and otherwise specified, shall be the rules and regulations for the proceedings of the NHS Greater Glasgow and Clyde Research Ethics Governance Committee.

NHS GREATER GLASGOW AND CLYDE

PHARMACY PRACTICES COMMITTEE

REMIT

1. Membership

1.1 The Committee shall comprise seven Members appointed by NHS Greater Glasgow and Clyde of whom:-

- (a) one shall be the Chair appointed by NHS Greater Glasgow and Clyde from the Non-Executive Members of the Board;
- (b) three shall be pharmacists of whom:-
 - (i) one shall be a pharmacist who is not included in any pharmaceutical list and who is not an employee of such person [known as Non-Contractor Pharmacist];
 - (ii) two shall be pharmacists each of whom is included in the Pharmaceutical List, or is an employee of a person who is so listed [known as Contractor Pharmacists];
- (c) three shall be persons appointed by NHS Greater Glasgow and Clyde otherwise from the Members of the Board [known as Lay Members].

1.2 NHS Greater Glasgow and Clyde shall appoint deputies for the Members of the Committee in a like manner to the seven Members.

1.3 In making appointments to the Committee of Members and Deputies NHS Greater Glasgow and Clyde shall ensure that the eligibility criterion in paragraph 3 of Schedule 4 of the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 1995 (as amended) are met.

1.4 Members shall be appointed for a term of three years, but NHS Greater Glasgow and Clyde shall reserve the right to remove any member at any time. Provided a quorum is present at any meeting, the proceedings of the Committee shall not be invalidated by any vacancy in its membership, or any defect in a Member's appointment.

2. Quorum

The quorum for Meetings of the Pharmacy Practices Committee shall be 5 members comprising:-

- Chair (or Deputy Chair)
- One Non-Contractor Pharmacist Member
- One Pharmacist Contractor Member
- Two Lay Members

(but see voting provisions at paragraph 4.2)

3. **Terms of Reference**

- 3.1 The Committee shall exercise the functions of NHS Greater Glasgow and Clyde in terms of Regulation 5(10) and paragraph 2 of Schedule 3 of the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 1995 (as amended) [determination of applications for general pharmaceutical contracts].
- 3.2 The Committee shall also be empowered by NHS Greater Glasgow and Clyde, to exercise other functions of as are delegated to it under the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 1995 (as amended) to the extent that those functions are not delegated to an officer of the Division under the Scheme of Delegation.
- 3.3 Any officer of the Division, with delegated authority in respect of the provision of General Pharmaceutical Services under Part II of the National Health Service (Scotland) Act 1978 (as amended), may refer to the Committee for determination 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. **Procedures**

The following procedures shall be adopted by the Committee:-

4.1 **Declaration of Interest**

Before the commencement of any meeting of the Pharmacy Practices Committee the Chair shall ask the Members intending to be present whether, in respect of any matter to be considered, any of them has an interest to declare or is associated with a person who has any personal interest. Any Member who has disclosed such an interest, or in the opinion of the Chair should have declared such an interest, shall not be present at the consideration or discussion of that matter or the voting on it.

4.2 **Voting**

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 (if present):-

- (a) the Non-Contractor Pharmacist Member
- (b) the Lay Members

The Chair (or Deputy Chair acting as Chair) shall not be entitled to vote except in the case of an equality of votes, in which case he or she shall have a casting vote.

In cases other than applications under Regulation 5(10) matters shall be determined by a majority of Members present and voting (including the Chair (or Deputy Chair if present)).

4.3 **Determination of Applications**

In considering all applications submitted to it the Committee shall have regard to the provisions of the National Health Service (General Pharmaceutical Services) (Scotland) Regulations 1995 (as amended) with particular reference to :-

- (a) consultation with interested parties; and
- (b) criterion for the granting of pharmaceutical contracts.

4.4 **Urgent Business**

- 4.4.1 The Chair of the Committee shall be empowered, in cases of urgency, (as to which the Chair shall be the sole judge on each occasion) to determine matters falling within the remit of the Committee (with the exception of applications submitted under Regulation 5(10)) in circumstances where it is considered necessary that, as a matter of urgency, a decision should be reached on an application between the scheduled meetings of the Committee.
- 4.4.2 The Chair shall not give approval to a proposal under this provision where there has been adverse representations received in response to the necessary consultation procedures carried out in respect of such matter or the Lead Pharmacist – Community Pharmacy Development (or Deputy) does not support the proposed decision.
- 4.4.3 Any decisions taken by the Chair on grounds of urgency conforming to the criterion above shall be reported to the next meeting of the Pharmacy Practices Committee for confirmation.
- 4.4.4 In the absence of the Chair, the Deputy Chair may act as the Chair for the purpose of this provision.

Approved by Trust Board 29th July 1999. Came into operation from 1st October 1999 on delegation of functions by the Health Board under the Health Act 1999
Amended to reflect change of title of Board to Trust Management Team from September 2001
Amended from April 2004 to reflect dissolution of the Trust
Amended from April 2007 to reflect inclusion of 'Clyde'

NHS GREATER GLASGOW AND CLYDE

AREA CLINICAL FORUMCONSTITUTION AND REMIT**1. INTRODUCTION**

The Area Clinical Forum is constituted under "Rebuilding our National Health Service" - A Change Programme for Implementing "Our National Health, Plan for Action, A Plan for Change", which emphasised that NHS Boards should both:-

- draw on the full range of professional skills and expertise in their area for advice on clinical matters; and
- promote efficient and effective systems - encouraging the active involvement of all clinicians from across their local NHS system in the decision-making process.

The Forum will be called NHS Greater Glasgow and Clyde Area Clinical Forum.

2. REMIT

To represent the multi-professional view of the advisory structures for medical, dental, nursing and midwifery, pharmaceutical, optometric, professionals allied to medicine and community health partnerships to NHS Greater Glasgow and Clyde ensuring the involvement of all the professions across the local NHS system in the decision-making process.

3. FUNCTIONS

The core functions of the Area Clinical Forum will be to support the work of NHS Greater Glasgow and Clyde by:-

- providing NHS Greater Glasgow and Clyde with a clinical perspective on the development of the Local Health Plan and the Board's strategic objectives.
- reviewing the business of the Area Professional Committees to promote a co-ordinated approach on clinical matters among the different professions and within the component parts of NHS Greater Glasgow and Clyde;
- promoting work on service design, redesign and development priorities and playing an active role in advising NHS Greater Glasgow and Clyde on potential service improvement;
- sharing best practice among the different professionals and actively promoting multi-disciplinary working - in both health care and health improvement;
- engage and communicate widely with local clinicians and other professionals, with a view to encouraging broader participation in the work of the Area Professional Committees;

At the request of NHS Greater Glasgow and Clyde, the Area Clinical Forum may also be called upon to perform one or more of the following functions:-

- investigate and take forward particular issues on which clinical input is required on behalf of the Board where there is particular need for multi-disciplinary advice.

- advise NHS Greater Glasgow and Clyde on specific proposals to improve the integration of services, both within the local NHS systems and across health and social care.

The Area Clinical Forum will review its functions periodically, in collaboration with NHS Greater Glasgow and Clyde to ensure that they continue to fit local priorities and developments.

4. **COMPOSITION**

The Area Clinical Forum will comprise the Chairs and Vice Chairs (or Deputy acting on behalf of Vice Chair) of the Area Professional Committees as follows:-

- Medical
- Dental
- Nursing and Midwifery
- Pharmaceutical
- Optometric
- Area Allied Health Professionals
- Community Health Partnerships

In Attendance

Persons other than Members may be invited to attend a meeting for discussion of specific items at the request of the Chairman or Secretary. That person will be allowed to take part in the discussion but not have a vote. NHS Greater Glasgow and Clyde Board's Director of Public Health, Pharmaceutical Adviser, Nurse Adviser and Consultant in Dental Public Health shall be regular attenders at meetings of the Area Clinical Forum.

5. **SUB-COMMITTEES**

The Area Clinical Forum may appoint ad hoc Sub-Committees as appropriate to consider and provide advice on specific issues.

6. **TERM OF OFFICE**

The Term of Office for Members will normally be up to four years. Individuals shall cease to be Members of the Area Clinical Forum on ceasing to be Chairperson/Vice Chairperson of their Professional Committee.

7. **OFFICERS OF THE FORUM**

(a) Chairman

The Chair of the Area Clinical Forum will be chosen by the Members of the Forum from among their number. The Forum's choice of Chair will be notified to the NHS Board Chair. Selection of the Chair will be an open process, and all Members who are Chairs of an Advisory Committee may put themselves forward as candidates for the position. If more than one person puts themselves forward an election will be held by secret ballot.

The Chair of the Area Clinical Forum will, subject to formal appointment by the Minister for Health and Community Care, serve as a Non-Executive Director of NHS Greater Glasgow and Clyde.

Membership of NHS Greater Glasgow and Clyde is specific to the office rather than to the person. The normal term of appointment for Board Members is for a period up to four years. Appointments may be renewed, subject to Ministerial approval.

Where the Members of the Area Clinical Forum choose to replace the Chair before the expiry of their term of appointment as a Member of NHS Greater Glasgow and Clyde, the new Chair will have to be formally nominated to the Minister as a Member of NHS Greater Glasgow and Clyde Board for a decision of formal appoint to the Board.

In the same way, if Board Membership expires and is not renewed, the individual must resign as Chair of the Area Clinical Forum, but may continue as a Member of the Forum.

(b) Vice Chairman

A Vice Chairman of the Area Clinical Forum will be chosen by the Members of the Forum from among their number. Selection of the Vice Chair of the Forum will be an open process and all Members who are Chairs of an Advisory Committee may put themselves forward as candidates for the position. If more than one person puts himself forward an election will be held by secret ballot.

The Vice Chairman will deputise, as appropriate, for the Chairman, but where this involves participation in the business of NHS Greater Glasgow and Clyde, they will not be functioning as a Non-Executive Member.

The Vice Chairman will serve for a period of up to four years.

8. **MEETINGS**

The Area Clinical Forum will meet at least four times each year. This can be varied at the discretion of the Chairman and meetings will normally be held in Dalian House.

The Forum has the right to alter or vary these arrangements to cover holiday months or other circumstances.

9. **NOTICE OF MEETINGS**

Secretariat support to the Area Clinical Forum will be provided by NHS Greater Glasgow and Clyde staff. The agenda and papers for the meetings will be issued at least one week in advance of the meeting date.

10. **MINUTES**

The Minutes of the meetings of the Area Clinical Forum will be agreed with the Chairman of the Forum and will be sent to each Member with the agenda and papers for the next Forum meeting, for approval. Thereafter, Area Clinical Forum Minutes will go to the next available NHS Board meeting for information.

11. **QUORUM**

A quorum of the Forum will be one third of its full membership. In the event that the Chair and Vice Chair are both absent, the Members present shall elect from those in attendance, a person to act as Chairperson for the meeting.

12. **FORUM DECISIONS**

Where the Forum is asked to give advice on a matter and a majority decision is reached, the Chairman or Secretary shall report the majority view but shall also make known any minority opinion and present the supporting arguments for both viewpoints.

13. ALTERATIONS TO THE CONSTITUTION AND STANDING ORDERS

Alterations to the Constitution and Standing Orders may be recommended at any meeting of the Forum provided a Notice of the proposed alteration is circulated with the Notice of the Meeting and that the proposal is seconded and supported by two thirds of the Members present and voting at the meeting.

Any alterations must be submitted to NHS Greater Glasgow and Clyde Board for approval as part of the annual review of Corporate Governance before the change is enforceable.

14. GUEST SPEAKERS

The Forum may invite guest speakers who it considers may have particular contribution to the work of the Forum to attend meetings.

SHIRLEY GORDON
Secretariat Manager
17 March 2006

**EAST DUNBARTONSHIRE COUNCIL
EAST RENFREWSHIRE COUNCIL
GLASGOW CITY COUNCIL
INVERCLYDE COUNCIL
NHS GREATER GLASGOW AND CLYDE
RENFREWSHIRE COUNCIL
SOUTH LANARKSHIRE COUNCIL
WEST DUNBARTONSHIRE COUNCIL**

**STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF
THE MENTAL HEALTH PARTNERSHIP COMMITTEE**

1. GENERAL

- 1.1 These Standing Orders are for the regulation of the conduct and proceedings of the Mental Health Partnership Committee (MHPC) of the Greater Glasgow & Clyde NHS Board (“the Board”) and any Subcommittees thereof.
- 1.2 These Standing Orders are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 [Scottish Statutory Instrument No 2001/302] (the Regulations).
- 1.3 The Mental Health Partnership Committee is coalition of the Board and of the constituent Councils (“the Councils”) established for the purpose of overseeing the functions of the Board and of the Councils as may be defined from time to time by the Board and the constituent Councils.
- 1.4 The constituent Councils of the Partnership shall be those Councils who have established with the Health Board, with the approval of the Scottish Ministers, one or more Community Health (and Care) Partnership under the terms of Sections 4A & B of the National Health Service Reform (Scotland) Act 2004.
- 1.5 The MHPC shall be a formally constituted Committee of the Board.
- 1.6 Any statutory provision, Regulation or Direction issued by the Scottish Ministers shall have precedence if they are in conflict with these Standing Orders.
- 1.7 These Standing Orders shall be subject to approval by the Board with the endorsement of the constituent Councils.
- 1.8 Any suspension, variation or revocation of these Standing Orders shall require the express consent of the MHPC, with the Head of Board Administration being so advised.
- 1.9 The MHP Director shall ensure that every Member of the MHPC is provided with a copy of these Standing Orders on appointment and with a copy of any subsequent amendment.

2. FUNCTIONS

- 2.1 The functions of the MHPC are as defined in Annex 1 and may be subject to variation from time to time by mutual agreement between the Board and the constituent Councils.

3. MEMBERSHIP

- 3.1 The constitution of the MHPC shall reflect a balance between health and council representation to operate the Mental Health Partnership (MHP) through a partnership approach, subject always to the Committee including in its membership at least one person who is a member of the Board.
- 3.2 Every person appointed to the MHPC shall, so far as practicable, be employed or perform services in, or have a substantial connection with, the area of NHS Greater Glasgow & Clyde.

- 3.3 Members of the MHPC shall subscribe to and comply with the Standards in Public Life – Code of Conduct for Members of Devolved Public Bodies, or the Code of Conduct for Councillors (in respect of members who are Councillors appointed by the constituent Councils of the Partnership).
- 3.4 Membership of the MHPC shall comprise the representation set out in Annex 2. Any amendment to Annex 2 shall have effect only when such amendment has been endorsed by the NHS Board and the constituent Councils.
- 3.5 Members of the MHPC shall be appointed by the NHS Board for a period of office not exceeding four years, chosen from nominations made by the nominating bodies specified in Annex 2.
- 3.6 Initial appointments to the MHPC shall be for the term set out in column (d) of Annex 2. Subsequent appointment shall be for the term set out in column (e) of Annex 2.
- 3.7 Where a Member resigns, or otherwise ceases to hold office, the person appointed in his/her place shall be appointed for the unexpired term of the Member they replace.
- 3.8 On expiry of a Member's term of appointment, the Member shall be eligible for reappointment if he/she remains eligible and is not otherwise disqualified from appointment.
- 3.9 Not less than three months before a Member's term of office is due to expire, the Head of Board Administration shall invite the nominating body to submit its nomination for future membership of the MHPC. Any nomination shall be effective from the date when approved by the NHS Board, or such other date as may be specified in the NHS Board's decision.
- 3.10 Notwithstanding Standing Order 3.9, Councils may nominate their Members for appointment to the MHPC after every Local Government election or otherwise during the Councillor's term of office.
- 3.11 Any Member appointed to the MHPC who ceases to fulfil the requirement of Standing Order 3.2 shall be removed from the membership on the serving by the NHS Board of notice to that effect on the Member. Such notice shall be issued by the Head of Board Administration under direction of the NHS Board.
- 3.12 A Member of the MHPC may resign his/her membership at anytime during his/her term of office by giving notice to the Head of Board Administration. The resignation shall take effect from the date notified in the notice or on the date of receipt if no date is notified.
- 3.13 If a Member has not attended three consecutive meetings of the MHPC, the NHS Board, through the Head of Board Administration, shall, by giving notice in writing to that Member, remove that person from office unless the NHS Board is satisfied that:
 - (a) The absence was due to illness or other reasonable cause; and
 - (b) The Member will be able to attend future meetings within such period as the NHS Board considers reasonable.

- 3.14 The NHS Board may, at its sole discretion, authorise a Subcommittee of the NHS Board to determine the appointment or removal of Members to the MHPC and authorise the absence of a Member for the purpose of Standing Order 3.13. A Subcommittee, if so appointed, shall include in its membership, at least two Members who are Members of a constituent Council.
- 3.15 The acts, meetings or proceedings of the MHPC shall not be invalidated by any defect in the appointment of any Member.

4. CHAIRPERSON

- 4.1 The Chairperson of the MHPC shall be an elected Member of one of the constituent Councils and also a Non Executive Member of the NHS Board who is appointed in that capacity by the Board following consultation with the constituent Councils.
- 4.2 At every meeting of the MHPC, the Chairperson, if present, shall preside. If the Chairperson is absent from any meeting, the Vice Chairperson, if present, shall preside. If both the Chairperson and Vice Chairperson are absent, the Members present shall elect a Chairperson for that meeting drawn from the elected Councillor representation or Non-Executive Board membership of the Committee.
- 4.3 The duty of the person presiding at a meeting of the MHPC is to ensure that the Standing Orders 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. VICE CHAIRPERSON

- 5.1 The MHPC shall appoint a vice chairperson from the elected Councillor representation or Non-Executive Board membership of the Committee.
- 5.2 The vice chairperson may act in all respects as the chairperson of the MHPC if the chairperson is absent or otherwise unable to perform his/her duties.

6. MEETINGS

- 6.1 The first meeting of a MHPC shall be held on such day and at such place as may be fixed by the Chairperson.
- 6.2 The MHPC shall meet at such place and as such frequency as it may determine but shall meet at least four times in each financial year.
- 6.3 The Chairperson may call a meeting of the MHPC at anytime and shall do so on receipt of a requisition, in writing for that purpose, which specifies the business to be transacted at the meeting and is signed by one-third of the whole number of the MHPC.
- 6.4 In the case of a requisition meeting, the meeting shall be held within fourteen days of receipt of the requisition and no business shall be transacted at the meeting other than that specified in the requisition.

- 6.5 If the chairperson refuses to call a meeting of the MHPC after a requisition for that purpose, or if, without so refusing, does not call a meeting within seven days after such a requisition has been presented, those Members who presented the requisition may forthwith call a meeting by signing the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the original requisition.

7. NOTICE OF MEETINGS

- 7.1 Before each meeting of the MHPC, a notice of the meeting, specifying the time, place and business to be transacted at it and signed by the Chairperson, the Director of the MHP (or nominee), shall be delivered to every Member or sent by post to the usual place of residence of such Members so as to be available to them at least five clear days before the meeting.
- 7.2 Members may opt, in writing addressed to the Director of the MHP, to have notice of meetings delivered to an alternative address. Such notification will remain valid until rescinded in writing.
- 7.3 Members may opt, in writing addressed to the Director of the MHP, to have notice of meetings and any associated papers delivered to them by electronic means to a specified e-mail address. Issue of notice and delivery of papers by electronic means shall be deemed to be received on the date of sending. Such notification will remain valid until rescinded in writing.
- 7.4 Lack of service of the notice on any Member shall not affect the validity of a meeting.
- 7.5 In the case of a meeting of the MHPC called by Members in default of the chairperson, the notice shall be signed by those Members who requisition the meeting in accordance with Standing Order 7.2.
- 7.6 The notice of the meeting shall be accompanied by such reports and papers that are to be considered at the meeting unless those papers are not available at the date of issue of the notice. Notwithstanding this, reports and papers must be delivered to every Member or sent by post to be available to them at least three clear days before the meeting.

8. QUORUM

- 8.1 No business shall be transacted at a meeting of the MHPC unless there are present, and entitled to vote, at least one-third of the whole number of Members of the MHPC of which at least two must be Councillors.

9. ADJOURNMENT OF MEETINGS

- 9.1 A meeting of the MHPC may be adjourned by a motion, which shall be moved and seconded and put to the meeting without discussion. If such a motion is carried by a simple majority of those present and entitled to vote, the meeting shall be adjourned to another day, time and place specified in the motion.

10. VOTING

- 10.1 All acts of, and all questions coming and arising before, the MHPC shall be done and decided by a majority of the Members of the MHPC present and voting at a meeting of the MHPC. Majority agreement may be reached by consensus without a formal vote. Where there is doubt, a formal vote shall be taken by Members by a show of hands, or by ballot, or any other method determined by the person presiding at the meeting.
- 10.2 In the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote.

11. CONFLICT OF INTEREST

- 11.1 If a Member or any associate of theirs has a pecuniary or other interest, direct or indirect, in any contract or proposed contract or other matter and that Member is present at a meeting of the MHPC, that Member shall disclose the fact and the nature of the relevant interest and shall not be entitled to vote on any question with respect to it. Such declaration or interest shall be recorded in the Minutes of the meeting and in the Register of Interests of the Board.
- 11.2 A Member shall not be treated as having any interest in any contract or matter if it cannot reasonably be regarded as likely to significantly affect or influence the voting by that Member on any question with respect to that contract or matter.
- 11.3 A Member who has an interest in service delivery may participate in the business of the Committee. Where the Member has a direct and significant interest in a matter, participation is only permissible where the Committee formally decides and records in the Minutes of the meeting that the public interest is best served by the Member remaining in the meeting and contributing to the discussion. During the taking of a decision by the Committee on such a matter, the Member concerned shall absent him/herself from the meeting.
- 11.4 In case of doubt as to whether any interest or matter should be the subject of a notice of declaration, Members should err on the side of caution and submit a notice/make a declaration or seek guidance from the Standards Commission, the Chairperson or Head of Board Administration as to whether a notice/declaration should be made.
- 11.5 Persons appointed to the MHPC as Members shall have one month from appointment to give notice of any registerable interest under the Codes of Conduct referred to in Standing Order 3.3 in each relevant category as specified in the standard form to be supplied by the Head of Board Administration.
- 11.6 Where the Codes referred to in Standing Order 3.3, require an interest to be registered, or an amendment to be made to an existing interest, this shall be notified to the Head of Board Administration in writing by giving notice in writing using the standard form available from the Head of Board Administration within one month of the interest or change arising. The Head of Board Administration will write to Members every six months to request them to review their declarations.
- 11.7 The Head of Board Administration will be responsible for maintaining the register of interests and for ensuring it is available for public inspection at the principal offices of the NHS Board

and at all reasonable times and via the NHS Board's website.

11.8 The register shall include information on:

- (a) The date of receipt of every notice.
- (b) The name of the person who gave the notice which forms the entry in the register.
- (c) A statement of the information contained in the notice, or a copy of that notice.

11.9 Members shall make a declaration of any gifts or hospitality received in his/her capacity as a Member of the MHPC. Such declarations shall be made to the Head of Board Administration who shall make them available for public inspection at all reasonable times at the principal offices of the NHS Board and on the NHS Board's website.

12. MINUTES

12.1 The names of the Members and others present at a meeting of the MHPC shall be recorded in the Minutes of the meeting.

12.2 The Minutes of the proceedings of a meeting, including any decision or resolution made at that meeting, shall be drawn up by the Head of Administration of the MHP (or nominee) and submitted to the next ensuing meeting for approval as to their accuracy, after which they will be signed by the person presiding at that meeting.

12.3 Minutes of meetings shall be submitted to the NHS Board and the constituent Councils by the Director of the MHP at the same time as they are circulated to Members of the MHPC.

13. SUSPENSION AND DISQUALIFICATION

13.1 Any Member of the MHPC may, on reasonable cause shown, be suspended from the MHPC on grounds of misconduct as determined by the Chairperson of the MHPC. Such suspension shall be an interim measure pending any decision taken by the nominating or appointing body on the removal of a Member.

13.2 Where a Member becomes disqualified, the Head of Board Administration shall give notice to the Member and the Director of the MHP in writing on behalf of the NHS Board, that being disqualified from membership, the individual's term of office has been terminated forthwith.

14. ADMISSION OF PUBLIC AND PRESS

14.1 The MHPC may, at its discretion, hold meetings open to the press and public.

14.2 If MHPC meetings are to be held in public, the members of the public and representatives of the press shall be notified of meetings and shall be admitted to the MHPC in accordance with the provision for the Public Bodies (Admission to Meetings) Act 1960.

14.3 Members of the public and representatives of the press admitted to meetings of the MHPC may be excluded from any meeting by decision of the MHPC where, in the opinion of the

majority of Members present, publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, or such other special reason as may be specified in the decision.

- 14.4 Representatives of the press and members of the public admitted to meetings shall require the authority of the MHPC for each occasion they may wish to record the proceedings of the meeting other than by written notes.
- 14.5 Members of the public may, at the chairperson's sole discretion, be permitted to address the MHPC, or respond to questions from Members of the MHPC, but shall not generally have a right to participate in the debate at MHPC meetings.
- 14.6 Nothing in the Standing Order shall preclude the Chairperson from requiring the removal from a meeting of any person or persons who persistently disrupt the proceedings of a meeting.

15. SUB-COMMITTEES

- 15.1 The MHPC shall appoint such sub-committees as they think fit (including any sub-committee to consider matters relevant to individual council areas). The remits of the MHPC subcommittees, their membership, quora and reporting arrangements shall be reviewed annually by the MHPC.
- 15.2 These Standing Orders shall apply to the proceedings of formally constituted sub-committees of the MHPC, subject to the following additional provisions:
 - (a) The sub-committee may invite to any meeting such persons from the Board or the constituent Councils as they think fit to assist in their deliberations and shall provide a right of access to the Board Chief Executive and Chairman.
 - (b) Sub-committees shall not be open to the public and press unless the MHPC decides otherwise in respect of a particular meeting.
 - (c) Minutes of the proceedings of sub-committees shall be drawn up by the Head of Administration of the MHP (or nominee) and submitted to the MHPC at the first scheduled meeting held not less than seven days after the meeting of the subcommittee for the purpose of advising the MHPC of decisions taken.
 - (d) A sub-committee may, notwithstanding that a matter is delegated to it, direct that a decision shall be submitted by way of recommendation to the MHPC for approval.

Remit, of the Mental Health Partnership Committee

The Mental Health Partnership has been established as a coalition of CH(C)Ps, the whole system part of a construct which has all local adult mental health services managed within CH(C)Ps.

Membership of the Mental Health Partnership Committee is drawn from constituent CH(C)P and the NHS Board. Such an arrangement ensures that the Partnership management team has a clear accountability route to CH(C)P interests for its responsibilities while local accountability for local services is achieved through the CH(C)P Management Teams and Committees.

The remit of the Mental Health Partnership Committee is to:

- ensure whole system accountability for delivery of mental health services across NHS Greater Glasgow & Clyde in partnership with CHC(P)s;
- monitor the performance of the mental health system;
- approve and monitor strategic mental health plans;
- approve and monitor financial investment programmes for mental health;
- ensure mental health networks are linked and working locally with local authorities across the NHS Greater Glasgow and Clyde area; regionally within the West of Scotland; and nationally across NHS Scotland;
- support CH(C)Ps in the discharge of their mental health responsibilities;
- develop effective links between mental health services and acute hospital services;
- lead the development of health improvement and prevention strategies for mental health in partnership with CHC(P)s;
- agree care governance and professional standards for all mental health services across NHSGGC, ensuring compliance with all relevant legislation and standards; and
- give statutory approvals on such matters as are delegated by the NHS Board in relation to the Mental Health (Care & Treatment) Act 2003 and the Adults with Incapacity (Scotland) Act 2000.

Constitution of Mental Health Partnership Committee

(a) Nominating Body	(b) Number of Members	(c) Qualification Requirement	(d) Initial Term of Office	(e) Term of Office After Initial Appointments
Greater Glasgow & Clyde NHS Board	2 (which includes the Chair who is an elected member of one of the constituent Councils and also a Non Executive Member of the NHS Board)	Non-Executive Board Members	4 years	4 years
Glasgow City Council	1	Elected Councillor	Next Local Government Election	4 Years
East Dunbartonshire Council	1	Elected Councillor	Next Local Government Election	4 years
West Dunbartonshire Council	1	Elected Councillor	Next Local Government Election	4 years
East Renfrewshire Council	1	Elected Councillor	Next Local Government Election	4 years
Inverclyde Council	1	Elected Councillor	Next Local Government Election	4 years
Renfrewshire Council	1	Elected Councillor	Next Local Government Election	4 years
Staff Partnership Forum	1	Officer of NHS Board who is nominated to represent the Mental Health Staff Partnership Forum	4 years	4 years

(a) Nominating Body	(b) Number of Members	(c) Qualification Requirement	(d) Initial Term of Office	(e) Term of Office After Initial Appointments
User Representative	1	From a voluntary organisation whose activities relate to the objectives of the MHP	2 years	2 years
MHP Director	1	Person appointed as Director of the MHP	So long as remains in post	So long as remains in post
Medical Director	1	Person appointed as Medical Director of the MHP	So long as remains in post	So long as remains in post
Nurse Director	1	Person appointed as Nurse Director of the MHP	So long as remains in post	So long as remains in post
CH(C)P Representatives	11 (one each from each CH(C)P #	Person appointed as CH(C)P Representatives	So long as remains in post	So long as remains in post
TOTAL	24			

The following will be invited to attend MHPC meetings to participate in proceedings but without voting rights	# CH(C)Ps to be represented on the Partnership Committee
<ul style="list-style-type: none"> • All CH(C)P Heads of Mental Health • General Manager, Forensic Services • General Manager Clyde Adult Acute • Joint General Manager for Learning Disabilities • Joint General Manager for Addictions • Head of Planning and Performance MHP • Head of Finance MHP • Head of Administration MHP • Head of Human Resources MHP • One officer representative of each Council for non-integrated CH(C)Ps • Health Board Officers by invitation 	Glasgow North Glasgow East Glasgow South East Glasgow South West Glasgow West East Dunbartonshire East Renfrewshire Renfrewshire West Dunbartonshire Inverclyde South Lanarkshire