Tayside NHS Board

A meeting of Tayside NHS Board will be held on **Thursday 27 October 2016 in the Steele Seminar Room, Perth Royal Infirmary at 9.30am.** Apologies/enquiries to: Donna Howey, 01382 740760 extension 40760 or e-mail donna.howey@nhs.net.

	AGENDA	LEAD OFFICER	REPORT NO	
1.	**Apologies**			
2.	**Chairman's welcome & introduction**	Prof J Connell		verbal report
3.	**Chief Executive's Update**	Ms L McLay		verbal report
4.	**Declaration of Interests Agenda items and any updates to the register** **This will include all interests whether or not entered on the Register of Interests, which would reasonably be regarded as so significant that they are likely to prejudice your discussion or decision making**	Ms M Dunning		verbal report
5.	**Minutes Of Previous Meeting**			
5.1	Minute of Meeting of Tayside NHS Board held on 25 August 2016	Prof J Connell		attached
5.2	Action Points Update	Ms L McLay		attached
5.3	Other Matters Arising	Prof J Connell		verbal report
6.	**Committees – Chairs Assurance Reports**			
6.1	Audit Committee	Mr S Hay	BOARD101/2016	attached
6.2	Clinical and Care Governance Committee	Mrs A Rogers	BOARD102/2016	attached
6.3	Finance and Resources Committee	Mr D Cross	BOARD103/2016	attached
6.4	Staff Governance Committee	Mrs A Rogers	BOARD104/2016	attached
7.	**Strategic Issues**			
7.1	Shaping Surgical Services	Dr A Russell/Prof P Stonebridge	BOARD105/2016	attached

7.2	Winter Planning Arrangements	Ms L Wiggin	BOARD107/2016	attached
8.	**Governance Issues**			
8.1	HAI Control in Tayside for July and August 2016	Mrs G Costello	BOARD99/2016	attached
8.2	Corporate Financial Report for Period Ended 30 September 2016	Mr L Bedford	BOARD108/2016	attached
8.3	Performance Report to August 2016	Ms L Wiggin/Dr A Cook	BOARD109/2016	attached
8.4	Update to the NHS Tayside Code of Corporate Governance	Ms M Dunning	BOARD110/2016	attached
8.5	Best Value Framework 2016/17	Ms M Dunning	BOARD111/2016	attached
8.6	Board Assurance Framework	Ms M Dunning	BOARD113/2016	attached
	Strategic Risks reported to the Board			
8.6.1	Infection Management	Dr A Russell	BOARD115/2016	attached
8.6.2	Health Equity	Dr D Walker	BOARD116/2016	attached
8.6.3	Sustainability of Primary Care	Ms V Irons	BOARD119/2016	attached
9.	**For Information – If items need discussion please raise with the Chair**			
9.1	Impact of Welfare Reform	Dr D Walker	BOARD100/2016	attached
9.2	Establishing Integrated Management and Development Arrangements for Primary Care in Tayside	Ms V Irons	BOARD126/2016	attached
9.3	Record of Attendance	Prof J Connell		attached
9.4	**Minutes of Meetings of Standing Committees**			
	Approved as a Correct Record			
9.4.1	Audit Committee – 21 June 2016	Mr S Hay		attached
9.4.2	Staff Governance Committee – 21 June 2016	Mr M Hussain		attached

Awaiting Committee Approval

9.4.3	Clinical and Care Governance Committee – 11 August 2016	Mrs A Rogers	attached
9.4.4	Finance and Resources Committee – 18 August 2016	Mr D Cross	attached
9.4.5	Audit Committee – 1 September 2016	Mr S Hay	attached

For Governance reasons, it is proposed that the following items be taken in reserved business.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemptions as listed

10. Minutes

10.1	Minute of Reserved Business of Tayside NHS Board 25 August 2016	Prof J Connell	attached
10.2	Minute of Reserved Business of Tayside NHS Board 27 September 2016	Prof J Connell	attached
10.3	Reserved Action Points Update	Ms L McLay	attached

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30

11. Committees – Chairs Assurance Reports

11.1	Remuneration Committee	Prof J Connell	BOARD127/2016	attached
11.2	Transformation Programme Board	Prof J Connell	BOARD128/2016	attached
11.3	Area Clinical Forum	Dr A Cowie	BOARD129/2016	Attached

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30

12. Strategic Risk Assurance

12.1	Waiting Times and RTT Targets	Ms L Wiggin	BOARD114/2016	attached
12.2	Capacity and Flow	Ms L Wiggin	BOARD117/2016	attached
12.3	NHS Tayside Estate Infrastructure	Ms L Wiggin	BOARD118/2016	attached

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30

13.	Mental Health Improvement Programme Contingency Plan	Mr B Nicoll	To follow

	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30			
14.	Staffing Issue	Mr G Doherty	BOARD120/2016	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30			
15.	Auditor General Report 2015/16 Audit of NHS Tayside	Mr L Bedford	BOARD130/2016	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30			
16.	Financial Forecast and Further Proposals	Mr L Bedford	BOARD121/2016	To follow
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30			
17.	Future Assurance Reporting	Mr G Doherty	BOARD122/2016	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30			
18.	Joint Inspection Report of Services for Children and Young People in Tayside	Mrs G Costello	BOARD123/2016	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30			
19.	NHS Tayside Executive Structure - update	Ms L McLay	BOARD124/2016	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30			
20.	Briefing from Director of Public Health	Dr D Walker		verbal report
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 33(1)			
21.	Property Disposal – Land and Buildings, Trades Lane, Coupar Angus	Mr L Bedford	BOARD125/2016	attached
22.	**For Information – If items need discussion please raise with the Chair**			
	Approved as a correct record			
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30			
22.1	Reserved Business Audit Committee – 21 June 2016	Mr S Hay		attached

	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30		
22.2	Reserved business Staff Governance Committee – 21 June 2016	Mr M Hussain	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30		
22.3	Area Clinical Forum – 30 June 2016	Dr A Cowie	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30		
22.4	Transformation Programme Board – 14 July 2016	Prof J Connell	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 27(2)		
22.5	East of Scotland Research Ethics Service REC 1 – 19 August 2016		attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30		
22.6	Transformation Programme Board – 24 August 2016	Prof J Connell	attached
	Awaiting Committee Approval		
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30		
22.7	Reserved Business Clinical and Care Governance Committee – 11 August 2016	Mrs A Rogers	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 33(1)		
22.8	Reserved Business Finance and Resources Committee – 18 August 2016	Mr D Cross	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30		
22.9	Area Clinical Forum – 25 August 2016	Dr A Cowie	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30		
22.10	Reserved Business Audit Committee – 1 September 2016	Mr S Hay	attached
	In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30		

22.11	Remuneration Committee – 27 September 2016	Prof J Connell	attached

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30

22.12	Transformation Programme Board – 28 September 2016	Prof J Connell	attached

23. Date of Next Meeting

The next meeting of Tayside NHS Board will be Thursday 1 December 2016 at 9:30am in the Board Room at Ninewells, Dundee

Prof J Connell
Chair
October 2016

Distribution

Board Members
Prof J Connell
Mrs G Costello
Dr A Cowie
Mr D Cross, OBE
Councillor D Doogan
Mrs L Dunion
Mrs J Golden
Mr S Hay
Mr M Hussain
Councillor K Lynn
Councillor G Middleton
Ms L McLay
Mr H Robertson
Mrs A Rogers
Prof A Russell
Prof M Smith
Mrs S Tunstall-James
Dr D Walker

Attendees
Communications Team
Mrs J Alexander
Mr L Bedford
Dr A Cook
Mr G Doherty
Mrs M Dunning
Mr T Gaskin
Miss D Howey

Minute NHS Tayside

TAYSIDE NHS BOARD

Minute of the above meeting held at 9:30am on Thursday 25 August 2016 in the Board Room, Kings Cross, Dundee.

Present

Non Executive Members

Dr A Cowie	Non Executive Member, Tayside NHS Board (to item 12)
Prof J Connell	Chairman, Tayside NHS Board
Mr D Cross	OBE, Non Executive Member, Tayside NHS Board
Councillor D Doogan	Non Executive Member, Tayside NHS Board
Mrs L Dunion	Non Executive Member, Tayside NHS Board
Mrs J Golden	Employee Director, Tayside NHS Board
Mr S Hay	Vice Chair, Tayside NHS Board
Mr M Hussain	Non Executive Member, Tayside NHS Board
Councillor K Lynn	Non Executive Member, Tayside NHS Board
Councillor G Middleton	Non Executive Member, Tayside NHS Board (to item 12)
Mr H Robertson	Non Executive Member, Tayside NHS Board
Mrs A Rogers	Non Executive Member, Tayside NHS Board
Professor M Smith	Non Executive Member, Tayside NHS Board
Mrs S Tunstall-James	Non Executive Member, Tayside NHS Board
Executive Members	
Mrs G Costello	Nurse Director, NHS Tayside
Ms L McLay	Chief Executive, NHS Tayside
Professor A Russell	Medical Director, NHS Tayside
Dr D Walker	Director of Public Health, NHS Tayside
Apologies	
Ms M Dunning	Board Secretary, Tayside NHS Board
In Attendance	
Mrs J Alexander	Partnership Representative
Mr L Bedford	Director of Finance
Dr A Cook	Medical Director, Operational Unit
Mr G Doherty	Director of Human Resources and OD, NHS Tayside
Mr T Gaskin	Chief Internal Auditor
Miss D Howey	Head of Committee Administration, Tayside NHS Board
By Invitation	
Dr M Bisset	Regional Medical Director, North of Scotland Planning Group (for item 5)
Ms L Hamilton	Mental Health Programme Director & Finance Manager (for item 8.2)
Dr K Ozden	Director of Mental Health Services / Associate Nurse Director (for item 8.2)
Dr G Phillips	Lead Infection Control Doctor (for item 9.4)
Dr N Prentice	Associate Medical Director for Mental Health (for item 8.2)
Ms L Wiggin	Chief Operating Officer (for item 9.3)

Professor J Connell in the Chair

ACTION

1. APOLOGIES

The apologies were as noted above.

2. CHAIRMAN'S WELCOME, INTRODUCTION AND KEY ISSUES

The Chairman welcomed all present. He highlighted the new layout of the Board agenda as requested by the Non Executive Board members. This included the for information section on the agenda. It was noted that this section would not be for detailed discussion unless specifically requested by a Board Member.

Other items were:

- The opening of the Dundee Young Persons Unit by Gemma Fay, Scotland's Women's Football Team captain
- The 40th anniversary of the opening of the Day Hospital at Royal Victoria
- The 5 year celebration of the Family Nurse Practitioners services. This had included the Cabinet Secretary for Health and Wellbeing. This service provided excellent support for young mothers
- The positive improvement in Lochee and Brechin general practice services was noted although not yet fully staffed. The Chairman asked the Board to note a letter from Lochee pressure group that had been delivered by hand that morning. He suggested that the pressure group should be asked to be involved in the patient participation group, if possible, and a meeting with the pressure group, could be held with himself and Mr Cross as the Chair of the Dundee Integrated Joint Board if required
- Discussion had been held with the Courier editor to develop a more positive approach to communications and local press coverage. A series of articles was planned to help explain some of the key changes that were planned in the NHS and in Tayside over next few years

The Board noted the Chairman's update

3. CHIEF EXECUTIVE'S UPDATE

The Chief Executive highlighted:

- There had been an unannounced visit Health Improvement Scotland (HIS) Inspection of Older People's Services in Tayside on 7 to 9 June 2016. A positive report had been received on this inspection; with seven areas of good practice highlighted. There were 15 areas for improvement that in the main covered documentation and governance. These were part of an improvement plan that was monitored by the Older Peoples Board and lessons learned would be highlighted across the whole care system
- A meeting had taken place in early August with the Chief Medical Officer and clinicians on progress with the Major Trauma Centres to be established in Scotland. It was noted that a Programme Lead had been appointed and the Board would be kept briefed on progress
- The Chief Executive paid tribute to Mr Alistair Adam, Clinical Services Manager, Critical Care who had taken premature retirement due to significant illness

The Board noted the Chief Executive's update

4. DECLARATION OF INTERESTS

No interests were declared.

The Chairman asked the Board to move item 7.1, Regional Clinical Strategy - The Case for Change next on the agenda and the Board agreed to this course of action.

5. Regional Clinical Strategy - The Case for Change (BOARD87/2016)

Dr M Bisset was in attendance and spoke to this report. He advised that he was the Regional Medical Director for the North of Scotland Planning Group (NoSPG) this strategy was being presented to each of the constituent Boards of NoSPG.

He gave a background history of the establishment of NoSPG and the need for collaborative working to sustain services. It was noted that the status quo was not now sustainable.

Clinical stakeholder events had been held last year as had the annual NoSPG Event in Inverness where there had been agreement to develop a regional clinical strategy.

Dr Bisset highlighted the important documents published earlier in the year that informed the strategy; the National Clinical Strategy and the Chief Medical Officer's Realistic Medicine report. These documents outlined the need to provide care in a more holistic and sustainable way on a national, regional and local basis.

The reasons for change were noted as the changing demographics of the population and workforce recruitment and retention issues across Scotland. It was noted that there were significant pressures in certain specialities.

Resilience was needed in services and there was more opportunity for this and sustaining quality services, if larger NHS Board areas supported and worked more collectively with smaller NHS Board areas.

Dr Bisset advised that a different model of governance was needed as currently some regional services were not working as effectively and efficiently as they could be. Significant change was required to plan and deliver services collectively.

The Chief Executive advised that the paper reflected the collaboration in place across NHS Scotland to sustain quality services. She highlighted the significant enablers to allow this to happen including technology and the importance of one common IT platform was stressed.

It was noted that the NoSPG Chief Executives had each been given leadership portfolios for areas of regional working. Ms McLay was the lead for the cancer portfolio and worked across the clinical communities.

Ms McLay commended the paper and that it provided a good indicator of the need for collaborative working between NHS Boards.

During discussion the following points were highlighted:

- There were other enablers to be considered and these included moving to a mindset to making effective use of all available funding for all parties in the region and ensuring public transport was considered when redesigning services. It was highlighted that it may not be patients that would need to travel, and there were examples of regional services where clinicians travelled to provide their service. There were constraints around

very special surgical procedures, where it may be necessary for the patient to travel, however, aftercare would be provided locally
- With the regionalisation of services, there was an opportunity for discussion on the implications and possible unintended consequences for higher education
- The potential for the reorganisation of NHS Boards and its implications were highlighted. It was noted that an implementation plan for the National Clinical Strategy was expected to be published in September 2016
- This would allow for an open and transparent discussion about the best outcomes for safe and effective patient care whether this was local, regional or nationally provided
- NHS Tayside was also a member of the South East and Tayside (SEAT) regional planning group

The Chairman noted that this had been a useful discussion. There was a move towards more regionalisation and strong communication would be needed with communities on how this would be taken forward.

The Board:

- **Thanked Dr Bisset for attending the Board meeting**
- **Noted the draft Regional Clinical Strategy Case for Change**

6. MINUTE OF PREVIOUS MEETING

6.1 Minute of Meeting of Tayside NHS Board held on 23 June 2016

The Minute of the Meeting of Tayside NHS Board held on 21 June 2016 was approved on the motion of Mrs S Tunstall-James and Mr S Hay.

6.2 Action Points Update

It was noted that the further information in relation to the bullying and harassment cases would come to the Board meeting in October in reserved business. **Director of HR and OD**

The Board noted the Action Points Update

6.3 Any Other Matters Arising

Mrs Tunstall-James queried the timescale for the recruitment of the new Non Executive Board Member. The Chairman advised that that advert was to be in place in the coming week. Interviews were scheduled for late October/early November 2016 and it was expected that the new Non Executive would be in post from 1 January 2017. The Chairman encouraged the Board to draw this vacancy to the attention of potential candidates.

7. COMMITTEES – ASSURANCE REPORTS FROM CHAIRS

7.1 Audit Committee

Mr Hay advised that the last meeting of the Audit Committee on 21 June 2016 had focussed on the Annual Accounts. The Annual Accounts had been discussed in detail at the Board meeting on 23 June 2016.

The Board noted the update from Mr Hay, Chair, Audit Committee

7.2 Clinical and Care Governance Committee

Mrs Rogers advised that the last meeting of the Clinical and Care Governance Committee had been held on 11 August 2016. She highlighted that the Committee had considered their aligned strategic risks and had agreed that the primary care risk should be aligned to the Clinical and Care Governance Committee.

The Annual Report of the NHS Tayside Donation Committee 2015/16 and the Feedback Annual Report 2015/16 had been positively received. The role of volunteers in gathering information had been acknowledged.

Complaints handling was an outlier and the Committee had been advised that the Nurse Director had commissioned work to address this as a matter of urgency.

Positive reports had been received in respect of out of hours provision, public health performance and the unannounced Mental Welfare Commission visit to Rohallion. There had also been discussion on Perth Royal Infirmary and the action plan for Murray Royal Hospital.

The Board noted the update from Mrs Rogers, Chair of the Clinical and Care Governance Committee

7.3 Finance and Resources Committee

Mr Cross advised that the Finance and Resources Committee had last met on 18 August 2016. He highlighted the new style of presentation for the corporate finance report, noting that the financial challenge was now clearly accessible to members. The hot spots, the overspend and the amount of non achievement of savings and what was planned in the Local Delivery Plan were now explicitly stated and could be easily understood.

It was highlighted that there needed to be an acceleration of the workstreams to meet anticipated saving. This had also been discussed at the meeting of yesterday's Transformation Programme Board.

There was also the intention to invite representatives from department areas who were significant "hot spot" areas to the Committee. This would allow the Finance and Resources Committee to see what progress was being made and to understand the pressures that areas were under.

Property and building maintenance had been considered. It was agreed that an update report would be taken to the Committee later in the year in advance of financial planning.

There had been detailed discussion about the NHS Scotland Pharmaceutical 'Specials' Service (NHSS PSS) Full Business Case, which was to be considered later in the Board agenda. Reassurance had been given to the Committee around the net contribution aspect and that this was a positive development for NHS Tayside as well as NHS Scotland.

Enhancements during Leave had also been discussed in detail and there was a proposal to be considered by the Board later in the agenda.

The Chairman highlighted that he was personally pleased on the focus taken on the backlog maintenance of property. He noted that this was a substantial amount across the NHS Scotland estate.

The Board noted the update from Mr D Cross, Chair of the Finance and Resources Committee

7.4 Staff Governance Committee

Mr Hussain highlighted that the last meeting of the Staff Governance Committee had been held on 21 June 2016. He highlighted the improvement in staff sickness levels and that this had been sustained, NHS Tayside had received a Carers Positive Award. This was presented to employers in Scotland who have a work environment where carers were valued and supported. He noted that concern had been expressed about partnership fora arrangements at this meeting of the Staff Governance Committee and a meeting of the local partnership fora chairs had been arranged and Mr Hussain was to be in attendance.

The Board noted the update from Mr M Hussain, Chair of the Staff Governance Committee

8. STRATEGIC ISSUES

8.2 Mental Health Service Redesign Transformation Programme (BOARD91/2016)

Dr K Ozden, Dr N Prentice and Ms L Hamilton were in attendance for this item. Dr Ozden gave the background to the option appraisal process that had taken place since this was last considered by the Board on 10 March 2016.

She advised that there had been two workshops held during June 2016; these had resulted in four potential options for the future configuration of adult mental health and learning disability inpatient services. All options considered looked at acute psychiatric admissions being provided from either a single site or two sites in Tayside. It was noted that the two options that scored highest from the option appraisal workshops, still saw a requirement for adult mental health services being provided from the existing three sites across Tayside, albeit the acute admissions wards were provided from a single site or from two sites. It was highlighted that the difference in scoring between the top four options was marginal and therefore would be included to ensure the scope requested for the production of an Initial Agreement on whether a single site or from two sites for acute adult psychiatric inpatient services were presented to the Board.

It was proposed that the Programme Team would now move to consider these four options in line with workforce models, safety and sustainability through a technical modelling workshop with key clinicians on 29 September 2016. A key issue required from the workshop would be the sustainability of the community models to support any amendments to the inpatient services.

The methodology used for the Option Appraisal Process was outlined. It was noted that this was covered in detail in the attached appendices to the report.

In outlining the recommendations to the Board, Dr Ozden highlighted in particular that the preferred option in all 4 option configurations suggested the potential relocation of low secure forensic learning disability services from Flat 1, Bridgefoot accommodation at the Strathmartine Hospital site to a low secure ward within the Rohallion Unit at Murray Royal Hospital. It was therefore requested whether this part of the Programme could be accelerated.

Outlining the governance and reporting mechanisms, it was noted that it was proposed that the Mental Health Service Redesign Transformation Programme should be reported through Perth & Kinross Transformation Programme and Integrated Joint Board with duplicate reporting and assurance to the NHS Tayside Transformation Board.

Dr Ozden advised that Dr Prentice was in attendance to answer any questions on medical workforce issues. Ms Hamilton could provide further detailed information on the option appraisal methodology and processes.

The Chairman thanked Dr Ozden, Dr Prentice and Ms Hamilton for the detailed and comprehensive approach that had been undertaken. He advised that he would like to consider each of the four recommendations in turn. He asked in the first instance for discussion on the process and if the Board was satisfied with the approach that had been taken as well as the wider engagement of stakeholders.

During discussion the following points were highlighted :

- The approach taken was very encouraging and the principles of this approach should be the way in which this was done in future. It had been an inclusive process both internally and externally
- It was good to have seen a greater level of engagement but there had been a reduction in the number of medical staff able to attend the workshops. This meant that the exercise lost some validity and there needed to be ownership of these proposals by those involved
- It was felt that these proposals were not what were originally requested by the Board as two options still had adult services being provided from three sites and felt there was a risk if the chosen option was not sustainable that the whole exercise would need to be undertaken again
- Engagement with staff side had been undertaken and this was welcomed, however, it would have been good to have seen what the workforce requirements would be

The Chairman asked the Board if overall they were content with the process that had been undertaken. The Board confirmed that they were content.

In respect of the second recommendation, the Option Appraisal report and its suggested progression, the Chairman noted that the process as outlined would slow down the timescale for a decision to be made. There was the potential for this process to take another two years before final completion.

There were three issues for consideration, the workforce impacts of these four proposed options; their sustainability; the clinical and care governance implications and possible risks to patient care; and the financial sustainability of all of these proposed options.

Dr Ozden advised that each of the four proposed options would be worked up and there would be an evidence base for workforce and financial sustainability. It was highlighted that lessons could be learnt from other NHS Board areas where similar models to the option that had scored highest had been introduced. The technical modelling workshop on 29 September 2016 would go through this work in detail. This would include strategic planning representation from the Integrated Joint Boards. This session would work up the workforce, clinical and care governance, sustainability and financial implications of each of the four options. Following this exercise a single preferred option would come back to the Board for consideration and then a further period of consultation undertaken.

It was noted that the 29 September session was a facilitated, technical session for clinicians and other staff. A further session would then be arranged to share this information and engage views with third sector organisations after that.

During discussion of this recommendation the following points were noted:

- It was felt that if there was no third sector organisations representation at the technical modelling workshop on 29 September, this would be seen as decision making behind “closed doors”. It was suggested that there should be third sector organisation representation at that session
- It was noted that the guidance issued by the Scottish Health Council was being followed in relation to this technical session. The session would consider the technical aspects of the proposals and the option appraisal process. The information could then be shared with third sector organisations and as many as possible would be encouraged to see this evidence
- An assurance was sought that there would be the data available to be able to demonstrate safety, sustainability and affordability
- Some elements of the requirements of major service change were outwith the control of the NHS Board. It was suggested that there needed to be agility around the processes to ensure there was the minimum of delay for patient safety. It was highlighted that the Medical and Nurse Directors would not support an option that was not safe
- The risk owner was queried and it was noted that the Medical Director/Deputy Chief Executive was the risk owner and the Chief Officer of the Perth and Kinross Integrated Joint Board was the risk manager

The third recommendation in relation to the consideration of the relocation of the low secure forensic learning disability services from Strathmartine Hospital to Rohallion Clinic at Murray Royal Hospital was discussed. It was noted that all four of the proposed options had included this as the preferred option. This would require the acceleration of the engagement processes with patients, families and staff. This would be a separate piece of work and would enable patients to be relocated to much improved facilities. It was reiterated that there had been no disagreement about this in all four of the options and this move would also support mitigation of current staffing risks.

It was noted that there were workforce implications associated with this and these would need to be addressed. There had been a lower level of Learning Disability staff at the workshops and there was a query about how this was reflected in the four options. It was noted that there was a Learning Disabilities workstream and a Learning Disabilities Reference Forum had been held prior to these workshops.

This proposal was agreed in principle but final decisions would be made following the submission of a further report detailing workforce, safety and financial implications. The Chief Executive advised that there would be resources put in place as required to support the production of the required business cases, reports and workforce planning requirements.

The reporting and governance of the Mental Health Service Redesign Transformation Programme was discussed in detail. It was noted that the decision on the one option needed to be jointly owned by the Board and the IJBs following consultation and engagement.

It was considered that there should be endorsement by the Board and all three Integrated Joint Boards of the decision on the preferred option which would then go out for consultation.

The timetable for decision making was highlighted. It was noted that this was outlined on page 23 of the report. The Initial Agreement would come to the Board on 1 December 2016 following consideration by the locality planning strategy groups, Area Partnership Forum, Area Clinical Forum, Angus, Dundee and Perth and Kinross Integrated Joint Boards, the Finance and Resources Committee and

the Capital Scrutiny Group. It was the intention to submit the Initial Agreement to the Scottish Government Capital Investment Group on 13 December 2016. There was detailed discussion on the time required to implement the new model and the continuing exposure to the current significant risks in relation to workforce and junior doctor training. There was a need for a contingency plan to be in place to sustain a safe service.

It was agreed that a detailed contingency plan for mitigating the risk, including a contingency model as well as the financial requirements needed to come to the next meeting of the Board in October 2016.

It was noted that all the models would be predicated on patterns of care in the community. This was not solely about the inpatient provision but the decisions regarding community based services made by the Integrated Joint Boards. It was agreed that the reporting and governance for the Mental Health Service Redesign Transformation Programme should be through all three of the Integrated Joint Boards with duplicate reporting and assurance to the NHS Tayside Transformation Programme Board and Tayside NHS Board.

The Board:

- **Confirmed they were satisfied with the attached report and that the process followed to identify the preferred options for future inpatient service provision, and in particular the wider engagement of stakeholders in the process had been satisfactory**
- **Noted the report on the Option Appraisal attached and approved that the Programme should be progressed in the stages outlined as advised above in relation to financial, patient safety and workforce sustainability**
- **Agreed that third sector organisations representatives should be involved in the end of September 2016 technical modelling workshop**
- **Agreed that after the September technical modelling workshop that the consultation process should involve the Integrated Joint Boards to bring forward a proposal for consideration in December 2016**
- **A contingency plan to sustain current services until the outcome was decided had to be developed and this would need to come to the next Board meeting** — **Director of Mental Health**
- **Gave consideration to the preferred option in all 4 configurations for low secure forensic learning disability services to be relocated from Strathmartine Hospital to the Rohallion Clinic at Murray Royal Hospital, and agreed that this part of the Programme could be accelerated, once a further report regarding implications on workforce and financial implications was produced and approved by the Board in December. It was noted that this would enable engagement and consultation to commence, with earlier progression of improvements for this service and patient group**
- **Considered and agreed that the proposal for reporting and governance for the Mental Health Service Redesign Transformation Programme should be through all three of the Integrated Joint Boards with duplicate reporting and assurance to the NHS Tayside Transformation Programme Board and Tayside NHS Board**

9. GOVERNANCE ISSUES

9.1 NHS Tayside Director of Public Health Annual Report 2015/16 (BOARD80/2016)

The Chairman introduced this item and highlighted that this report and the Dundee

Fairness Commission report would form part of the Board Development Event session to be held on 29 September 2016.

Dr D Walker presented his report. He welcomed the opportunity to discuss his report in more detail at the Development Session on 29 September, highlighting that this would cover arrangements for community planning, health equity and communities in control and the report of the Fairness Commission.

Dr Walker highlighted that this was the third cycle of reporting sections of his annual report to the Board. It was an excellent reflection of the work undertaken by public health staff. This covered work undertaken locally, regionally and nationally and there were excellent relationships in place with partners.

The two other reports mentioned in the foreword to the Director of Public Health Annual Report were A Fair Way to Go and the Chief Medical Officer Annual Report - Realistic Medicine. Dr Walker encouraged all Board Members to read both reports. He highlighted that the A Fair Way to Go report was explicit about the challenge of poverty and deprivation. The Realistic Medicine report set out the future agenda to be faced by the medical profession. Dr Walker gave an example case study of an older man with pneumonia and the different approaches that could have be taken rather than a medical based model approach.

Dr Walker noted that he was looking forward to the Development Session on 29 September for a more detailed and in depth discussion of his report.

The Chairman noted that this was an excellent report. He welcomed the three year rolling report cycle with the focus on reviewing the outcomes from recommendations. He highlighted NHS Tayside as an employer with a duty to its workforce to pay fair wages and to treat staff appropriately and health inequalities would be of focus at the Development Session on 29 September 2016.

During discussion the following points were noted:

- There was a focus on therapeutic nutrition in this annual report as other areas of nutrition had been covered in previous annual reports
- In relation to children's oral health, there were a number of different programmes that covered fluoride varnishing, supervised tooth brushing as well as the Childsmile programme
- In relation to access to talking therapies against the prescribing of anti depressants for mental health, it was felt that there was an over reliance on medication rather than lifestyle approaches such as talking therapies
- The feedback on progress from previous Director of Public Health Annual Reports made was welcomed
- The reporting mechanisms for the Health Equity Governance Board were queried. It was suggested that this should be via the Clinical and Care Governance Committee and the Chief Executive and the Director of Public Health would discuss this outwith the Board meeting
- The use of free mobile phone apps to assist with physical inactivity was highlighted and discussed. The use of these apps in a semi competitive way was encouraged
- The difference between drug related hospital stays and alcohol related stays (400% higher) as described in table 3 of page 30 of the report was noted as was the public acceptance of the misuse of alcohol against the misuse of drugs. There was an ambivalence about alcohol and an underestimation of the impact that alcohol had on health and well being
- Dr Walker advised that he was the Chair of the Tayside Alcohol and Drug Partnership. They sought advice on a range of initiatives for both alcohol and drugs. There was a Drug Deaths Group established and the soon to be published annual drugs death report would show there had been 48 drug related deaths in Tayside in 2015/16. It was noted that this was a

relatively stable figure. A drugs initiative in Glasgow was highlighted whereby there was supervision of users taking heroin. This was still under discussion as due to legal and political issues. The NHS Scotland Directors of Public Health had expressed their support for this proposal

- The accessibility and style of the annual report was acknowledged. It was highlighted that there was a need to consider self stigma as this was a major issue associated with health inequalities. It was suggested that this could be covered in the Board Development Session on 29 September 2016
- There were also opportunities to engage with the University of Dundee in a structured way about health and well being inequalities. Professor Smith and Dr Walker would discuss this outwith the Board meeting

The Board:

- **Noted and welcomed the Director of Public Health Annual Report 2015/16 and agreed to its recommendations being considered by the local NHS and other stakeholders**
- **Noted that this Annual Report was to be a topic at the Board Development Event on 29 September 2016**

9.2 Corporate Financial Report for Period Ended 30 June 2016 (BOARD92/2016)

The Director of Finance spoke to this report. He advised of the build of a new corporate finance reporting structure; recognising that this was in its early formative stages. He noted that it was not the intention to replicate this detail in future reports to the Board, but thought it would be helpful to give a feel for how corporate reporting was developing and to bring to the Board's attention, what had been reported at the Finance and Resources Committee the previous week.

It was noted that the reporting of the Integrated Joint Board position would also evolve over the forthcoming months. This would recognise the change of status for this delegated resource as approved by the Board in March as part of the Financial Framework.

In terms of key points, it was noted that the Quarter 1 position was an overspend of £4.480 million as against a position of £2.884 million at May 2016. This was an increase on the deficit of £1.596 million in the month. Based on this and in relation to the unbalanced Local Delivery Plan position submitted to the Scottish Government at the end of May, a deterioration of close to £1 million was anticipated each month. This position was demonstrated by the Core Operational function in Table 1 and subjectively in Table 2 on page 2 of the report.

It was noted that the Financial Framework approved by the Board in March 2016 sought to resolve a number of legacy issues. These were reflected in the base budgets that the operational and strategic functions received at the commencement of the year, however, it was noted that the efficiency savings challenge, both in the present year, and in the medium term were well recognised by all.

In reporting the position at Quarter 1 , the Director of Finance advised that the Board contingency remained undistributed.

It was noted that the Integrated Joint Boards had each considered proposals on efficiency savings at their meetings in June 2016. All three Integrated Joint Boards had intimated their intention to invoke the risk sharing agreement in respect of the devolved GP Prescribing budget and the risk around its delivery.

In summary terms, the position at the end of quarter 1 was a £4.480 million overspend covering a £2.9 million unbalanced Local Delivery Plan, £1.2 million shortfall on efficiencies and circa £0.4million net cost pressures.

It was noted that subjectively, pay was showing an overspend of £1.4 million and the position by job family was reported in Table 3 of the report. Chart 1 showed both the monthly spend profile and also the trend in Whole Time Equivalent (WTE) worked. Fluctuations in the spend profile each month were mainly anticipated recognising the payroll timetable for both weekly paid staff and also enhancements and was shown in Table 4 of the report.

It was noted that the WTE staff level had fallen by 173 since March 2016. It was also highlighted that supplementary costs had fallen by £351,000 since the same period in the last financial year. Whilst this was not as high as perhaps had been anticipated, the impact of the reduced WTE was having an overall financial benefit. The graphs on supplementary costs were shown in Appendix 2 on the final page of the report.

The Director of Finance highlighted that pressures remained within a number of non-compliant medical rotas. Whilst a few of these were now compliant, the costs remained until the training grade changeover in August 2016. The costs burden would then lessen assuming continued compliance. It was noted that the cost pressure to date was £0.3 million.

It was noted that winter surge beds on the Ninewells site remained open with no identified funding source. This reflected the continued patient flow. The surge beds at Perth Royal Infirmary had closed in June 2016. There was a cost pressure of £0.34 million identified to date associated with these surge beds.

In relation to prescribing, the table and chart on Page 4 of the report outlined the position. It was noted that secondary care medicines continued to support the position overall, with the well documented challenge with FHS prescribing costs already evident. There was a shortfall brought forward from 2015/16 of circa £0.2 million. The three Integrated Joint Boards had already indicated through their own governance processes, the challenge of remaining within the identified financial limits. It was noted that the Prescribing Management Group continued to work collaboratively.

The one off benefits on energy were showing in the early months however the budgeted resource has reduced recognising the national prices negotiated in particular for gas. It was noted that clinical supplies continued to be impacted by demand pressures.

The Individual Group positions were provided in Section 3.7 of the report with the intention of bringing a greater level of understanding on each aspect of the organisation. This was both in terms of trends and also particular areas of traction in containing costs and also where pressures were evident. The aim was to enhance this in future months to the Finance and Resources Committee to recognise forecast outturn positions. It was not the intention to go through this information on a Group by Group basis, but the aim was to provide information at this level, that was both helpful and informative. It was noted that as the supporting organisational structure underneath the Chief Operating Officer was agreed and implemented, there may need to be changes to the reporting Group structure.

Information on the Integrated Joint Boards was also reported, although at this stage, it did not reflect the internal cross charging for hosted services between each of the three bodies. This would be in place for July and was based on an agreed split. Each of the Integrated Joint Boards held governance meetings prior to the end of June 2016. All three Boards noted the risk around delivery of the

devolved GP Prescribing budget with challenges around the Forensic Medical Service and also the locum spend position in both General Adult Psychiatry and Learning Disability. This was due to the recruitment difficulties and these were not expected to be resolved in the short term.

Table 19 on page 13 of the report gave the current status of efficiency savings. It was noted that these had been discussed in detail at the Transformation Programme Board. The efficiency savings reflected an unbalanced Local Delivery Plan of £11.65 million. It was noted that the shortfalls to date were against three headings - Workforce, Operational Savings and within the Integrated Joint Boards. Work was ongoing with the Integrated Joint Boards to see how their plans aligned with the Transformation Programme.

It was highlighted that through information available from the rostering system and the Safecare System; opportunities have been identified to manage time out more effectively. It was anticipated that this would have a direct correlation to reducing supplementary costs in future months. The availability of this information and analysis from the electronic system was now beginning to drive a greater understanding of current practice. The shortfall against prescribing was a component that had already been identified as had the challenges within the Integrated Joint Boards on supplementary costs.

An assessment on the delivery of savings on a recurring basis would be included in future reports to the Finance and Resources Committee. This would include the assessment of what could be delivered in 2016/17 and this would be assessed as part of the forecast outturn. The Board contingency had not been distributed at this stage and a proposal for its use would come forward to the Finance and Resources Committee.

The Chairman thanked Mr Bedford for his report and noted that it was now much more accessible. The Chief Executive noted that the objective was to bring the financial situation into balance in this financial year. It was unlikely that this would happen and detailed plans had to be put in place for the last six months of the financial year. She highlighted that the programme of transformation work had been shared with the other two NHS Boards who also had submitted unbalanced Local Delivery Plans. The biggest issue was the pace and delivery of efficiencies and savings. The focus in the coming weeks would be the delivery model that was needed to tackle the scale and volume and to accelerate what was required. The potential for regional and joint transformation work was also acknowledged.

During discussion the following points were highlighted:

- There was now greater clarity on the financial situation and what was now needed was the delivery of change. There needed to be an acceleration of the delivery of pace and prioritisation. The actions/options that would be required should these plans not be delivered also had to be articulated
- There was a need to ensure that the message was getting across the whole of the organisation that improved efficiency was not optional and had to be delivered. It was noted that the medical community had an understanding and desire to make this work, but, there was a challenge in relation to service provision decisions that were being delayed due to external factors
- The clinical community also had a focus on patient safety and ensuring that workforce models reflected patient safety. Workforce and care assurance systems were continually risk assessed. Staff were committed to change but this had to be safe for patients and staff

The Board:

- **Noted the current position and supported the actions being taken by management to contain spend**
- **Noted that scrutiny of financial performance would continue to be undertaken by the Finance and Resources Committee and the Transformation Programme Board**

9.3 Tayside NHS Board Performance Report to June 2016 (BOARD93/2016)

Ms L Wiggin and Dr A Cook were in attendance and spoke to the Performance Report to June 2016.

Ms Wiggin gave an overview update and advised on the position as at June 2016. Points of note were the improving NHS Tayside performance position of note were:

- Accident and Emergency 4 hour waits highest performance in Scotland
- Child and Adolescent Mental Health Services 18 week performance of 100% with the standard now met for 7 consecutive months
- Psychological therapies 18 week performance was back on track
- Drug and alcohol, cancer 31 days and IVF continuing to demonstrate positive performance
- An improving position in diagnostics with NHS Tayside 3rd out of all the NHS Boards in Scotland.

There were challenges with:

- Treatment Time Guarantees (TTG), however, position improving against the other Scottish Boards with performance ahead of the trajectory submitted to the Board at the June 2016 meeting
- New outpatients performance when compared to other Boards, NHS Tayside was ranked 6 out of 11 Boards, with 1 being best performance
- Diagnostic 8 key tests improving performance ranked third against other NHs Scotland Boards
- Static performance with 18 weeks target
- Cancer 62 day performance continues to be a challenge. The two main issues were colorectal where the service had a single handed consultant and breast where there were issues related to the national IT system that had resulted in greater than normal numbers of referrals that impacted on screening and treatment

It was noted although same day surgery rates had been met there was still room for improvement with the Ninewells site performing less well than the Perth Royal Infirmary site.

In relation to the average length of stay, there were now huddles three times per day on the Ninewells and Perth Royal Infirmary sites to support how patients were flowing through the system. A day of care audit was also to be undertaken on 1 September 2016, similar to the one undertaken at Perth Royal Infirmary. This would inform improvements that could be made across patients' pathways in support of reducing length of stay.

There was still a high volume of delayed discharges in Perth and Kinross and although it was acknowledged that this was an improving position; it was too early to understand if this was sustainable.

Dr Cook advised on readmission rates and he highlighted an improving position at Perth Royal Infirmary. He outlined the work that had been undertaken looking at national comparators and readmissions. The differences in some sub specialities were noted. Consideration was being given to a model for managing patients when discharged as well as a sub specialities model of support.

It was noted that the Hospital Standardised Mortality Rate (HSMR) remained above the required Scottish average and rates of pressure ulcers and falls were broadly static.

During discussion the following points were highlighted:

- The improvements in Child and Adolescent Mental Health Services and psychological therapies was encouraging
- The Scottish Government Health and Social Care Directorate was to review the requirement for these national targets and one of the key issues was re admission rates
- The reasons for the variance in the 31 and 62 day cancer waiting times were discussed in detail. It was noted that the national cancer team was involved. It was unlikely that the cancer targets would stabilise. NHS Tayside, following a national request, was also supporting NHS Fife in relation to radiology
- No difference appeared to being made in relation to falls performance and this should be addressed. It was noted that while a sustained improvement had not been shown, the comparative position was different. Improvements had been introduced and changes had been made in the management of patients who had falls. At each directorate performance review, each fall was considered as was the required system wide changes
- The complaints information was of concern and there appeared to be no downward trend and no sustained improvement either. The system was being urgently reviewed by the Nurse Director and the Chief Operating Officer

The Board:

- **Noted the Performance Report to June 2016**

9.4 HAI Control in Tayside for May and June 2016 (BOARD82/2016)

Dr G Phillips was in attendance and spoke to this report. She advised that there had been an outbreak of norovirus in one ward with a high attack rate and a rather more prolonged course than normally seen in the May to June 2016 period.

In relation to *Staph aureus* bacteraemias, it was noted that there had appeared to be an upward trend, however, an in-year change in denominator of acute occupied bed days appeared to be elevating the rate with the total number relatively stable (these include community acquired infections).

Clostridium difficile was above target but was relatively stable and hospital acquired infection had reduced in the last six months.

During discussion it was noted that other NHS Boards had norovirus outbreaks but not as extended as had been seen in Tayside.

The Board:

- **Noted the HAI Control report in Tayside for May and June 2016**

9.5 Integration/IJBs Update

The Chairman noted what had been achieved since the formal inception of the Integrated Joint Boards on 1 April 2016. He paid tribute to all those who had

worked hard to achieve this in Angus, Dundee and Perth and Kinross. He noted that this would be a standing item on the Board agenda.

The Chief Executive acknowledged the pace of change from 1 April 2016 and the transition to the devolved services (with the exception of the mental health service). There had been a huge amount of work and collaboration to get to this stage.

It was noted that the performance framework was currently being considered. It was important that this framework demonstrated key performance indicators and governance. There needed to be one core data set and any variation reporting should be reported through the Board's standing committees as a lead officer responsibility. It was noted that the intention was to bring a report to the October Board meeting on progress with developing this governance and reporting framework.

The Medical Director advised that the areas of the mental health risk retained by NHS Tayside would be managed and reported on as part of the group too.

The Board:

- **Noted the verbal update given by the Chief Executive**

10. FOR INFORMATION

10.1 A Fair Way to Go – Report of the Dundee Fairness Commission (BOARD81/2016)

The report was noted for information and would be a topic at the Board Development Event on 29 September 2016.

10.2 Draft Area Clinical Forum Annual Report 2015/16 (BOARD83/2016)

The draft Annual Report 2015/16 was noted for information.

10.3 People Matter Strategic Framework (BOARD84/2016)

The Board noted the People Matter Strategic Framework that had been considered in detail by the Staff Governance Committee.

10.4 Scottish Patient Safety Programme in Primary Care Update (BOARD85/2016)

The Board noted this update report.

10.5 Minutes of Meetings of Standing Committees

Approved as a Correct Record

10.5.1 Finance and Resources Committee – 12 May 2016

This Minute was noted.

10.5.2 Clinical and Care Governance Committee – 12 May 2016

This Minute was noted.

11. Record of Attendance

The Record of Attendance was noted for information.

For Governance reasons, it was proposed that the following items be taken in reserved business. The Board agreed to take Item 13 Strategy for Internationalising Healthcare Delivery as the first item in reserved business and then break for lunch.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 33(1)

12. Strategy for Internationalising Healthcare Delivery (BOARD86/2016)

The Board endorsed Report BOARD86/2016.

13. MINUTES

In accordance with the Freedom of Information (Scotland) Act 2002 Exemptions as listed

13.1 Minute of Reserved Business of Tayside NHS Board held on 23 June 2016

The Minute of the Reserved Business of Tayside NHS Board held on 23 June 2016 was approved.

13.2 Reserved Action Points Update

The Reserved Action Points Update was noted.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30

14. COMMITTEES – ASSURANCE REPORTS FROM CHAIRS

14.1 Remuneration Committee (BOARD89/2016)

The Board noted the update given by the Chairman.

14.2 Transformation Programme Board (BOARD88/2016)

The Board noted the update given by the Chairman.

14.3 Area Clinical Forum

The Chairman advised that Dr Cowie had left to attend another meeting.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 27(1)

15. Financial Presentation

The Board noted the financial presentation given by the Director of Finance.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 33(1)

16. NHS Scotland Pharmaceutical 'Specials' Service (NHSS PSS) Full Business Case (BOARD90/2016)

The Board approved the recommendations in Report BOARD90/2016.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30

17. Staffing Issue (BOARD94/2016)

The Board noted the update.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 33(1)

18. Property Disposal – Land and Buildings Murray Royal Hospital (BOARD95/2016)

The Board approved the recommendations in Report BOARD95/2016.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 33(1)

19.. Property Disposal – Land and Buildings Little Cairnie Hospital (BOARD96/2016)

The Board approved the recommendations in Report BOARD96/2016.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30

20. Enhancements During Leave (BOARD97/2016)

The Board discussed and agreed the recommendations made by the Finance and Resources Committee.

21. For Information

Minutes of Meetings of Standing Committees

Approved as a correct record

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 33(1)

21.1 Reserved Business Finance and Resources Committee – 12 May 2016

The Minute was noted.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30

21.2 Reserved Business Clinical and Care Governance Committee – 12 May 2016

The Minute was noted.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30

21.3 Transformation Programme Board – 18 May 2016

The Minute was noted.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30

21.4 Area Clinical Forum – 26 May 2016

The Minute was noted.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 27(2)

21.5 East of Scotland Research Ethics Service REC 1 – 17 June 2016

The Minute was noted.

Awaiting Committee Approval

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 30

21.6 Remuneration Committee – 21 June 2016

The Minute was noted.

In accordance with the Freedom of Information (Scotland) Act 2002 Exemption 27(2)

21.7 East of Scotland Research Ethics Service REC 1 – 15 July 2016

The Minute was noted.

22. Date of Next Meeting

The next meeting of Tayside NHS Board will be held on Thursday 27 October 2016 at 9:30am in the Board Room, Kings Cross

The Chairman advised that it was hoped that the October Board meeting could be held out with Dundee and that there was potential for this to be arranged in Perth Royal Infirmary.

Actions Points Update **NHS Tayside**

Tayside NHS Board – 27 October 2016

	Meeting	Minute Reference	Heading	Action Point	Responsibility	Status
1.	23/6/2016	8.3	Any Other Matters Arising – Bullying and Harassment	More detail on the 17 cases of bullying and harassment in NHS Tayside during 2015/16 to be sent to the Board	Director of Human Resources and OD	Formal assurance report to come to the Board on 27 October 2016 in reserved business
2.	25/8/2016	8.2	Mental Health Service Redesign Transformation Programme	A contingency plan to sustain this service until the outcome of the programme was known to be developed and this would need to come to the next Board meeting	Director of Mental Health	Agenda item 27 October 2016

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item 6.1

BOARD101/2016
Tayside NHS Board
27 October 2016

COMMITTEE CHAIR'S ASSURANCE REPORT

AUDIT COMMITTEE – 1 September 2016

Performance against work plan
The Director of Finance updated the Committee on work done in response to Internal Audit's Interim Evaluation of Internal Control Framework presented to the Committee at its meeting in February 2016. This remains a work in progress and the Committee will receive a further update in December.

The Committee scrutinised the Best Value Framework and while agreeing the updated model was an improvement felt it needed a final tightening up before going to the Standing Committees. In particular the responsibilities of the Transformation Board and the Standing Committees require clarity.

Update on Risks
The Property Transaction report gave the Committee concerns that the property department is stretched and under pressure and that a refresh of procedures may be required.

The Committee received a very comprehensive report on the new payment verification processes and has been asked to feedback to the author.

Delegated Decisions taken by the Committee
None

Any Other Major Issues to highlight to the Board
None

Horizon Scanning
A theme running through this session was the challenge in recruiting to posts in finance, property and medical instrumentation. This remains a challenge for NHS Tayside across a wide range of other areas and needs to be addressed.

AUDIT COMMITTEE – RESERVED BUSINESS, 1st September 2016

There is nothing to highlight to the Board outside the minute of the meeting

Stephen Hay
Audit Committee Chairman
October 2016

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item 6.2

BOARD102/2016
Tayside NHS Board
27 October 2016

COMMITTEE CHAIR'S ASSURANCE REPORT

Clinical and Care Governance Committee

Thursday 11 August 2016

Performance against workplan
The committee has undertaken the work in the 2016/2017 workplan to date.

Update on Risks
- The Maternity Services risk had achieved the planned risk exposure and consideration should be given to archiving this risk or to consider this as a service level risk for Maternity Services.
- The Committee noted that the Managed/ 2C General Practice Provision Risk would be aligned to the Clinical and Care Governance Committee. The owner of this risk is the Medical Director and the manager is the Associate Medical Director, Primary Care.
- It was agreed that the assurance report template would be used for all future reporting of strategic clinical risks to the Committee and that the covering table would be provided to show the position on a rolling basis month to month to enable a trend analysis. It was agreed that Datix reports would not be required but could be included as a separate appendix for information.

15 Delivering Care for Older People

Owner – Gillian Costello	Yellow Risk
No change to the owner	No change to the scoring of this risk

This risk was last updated on 12 July 2016 and continued to be updated by the risk manager after each meeting of the NHS Tayside Older Peoples Clinical Board. The risk review date was 25 October 2016.

16 Clinical Governance

Owner – Andrew Russell	Amber Risk
No change to the owner	Change to the scoring of this risk

The risk was downgraded in April 2016 and was reported at the CCGC. The risk is continually reviewed by the Head of Clinical Governance and Risk.

22 Health Protection of Children and Young People

Owner – Gillian Costello
No change to the owner

Yellow Risk
No change to the scoring of this risk.

There would be a review of this risk week commencing 15 August 2016. The current risk manager is retiring and consideration will be given to a new risk manager. Noted also that outcomes from the Angus Inspection for Children's Services may impact on the risk score.

23 Mental Health Services

Owner – Karen Ozden
No change to the owner

Risk now an Operational Risk

Ms Walker advised that this risk had been updated and downgraded in status to an operational risk to focus on improvement work. It has been replaced by new strategic risk ref no 395. There will be further discussion at the Strategic Risk Management Group on 15 August 2016 in respect of the owner and manager.

121 Person Centredness

Owner – Gillian Costello
No change to the owner

Yellow Risk
No change to the scoring of this risk

There were no issues to be highlighted to the Committee.

144 Maternity Services

Owner – Gillian Costello
No change to the owner

Amber Risk
No change to the scoring of this risk

This risk had achieved the planned risk exposure.

3 PRI Patient Flow
0
2

Owner – Alan Cook
No change to the owner

Amber Risk
A change to the scoring of this risk

Dr Cook advised that the risk had been downgraded on 3 August 2016. The next review would be on 3 November 2016.

Delegated Decisions taken by the Committee

- The committee noted the progress to date in relation to the development of the Duty of Candour guidelines and requested an update at each meeting.
- The Committee adopted the following policies:

Extravasation Policy

Covert Medication Policy

Prescribing of Non Formulary Medicines (including Individual Patient Treatment Requests)

Review of the Policy for Records and Record Keeping for Nursing and Midwifery Staff

Any Other Major Issues to highlight to the Board

- During discussion of the Annual Feedback report, there were concerns raised in relation to the fall in complaints response time to 46%. In relation to Health and Social Care Partnership complaints and NHS sign off it was important that there was no further delay to reply letters. A review of NHS Tayside complaints handling process and a national review are occurring during 2016-2017. The Nurse Director, the Chief Operating Officer and an external consultant would be supporting the NHS Tayside review. Feedback and complaints are discussed regularly at Senior Leadership Team meetings and at Performance Review meetings
- With regard to the Out of Hours service, there is a requirement for robust recruitment and retention for GPs, Occupational therapists, pharmacy and nursing staff to ensure sustainable models of care, the development of relationships with the Scottish Ambulance Service in respect of primary responders and a need to improve the interface with IT systems
- The Committee requires assurances from both NHS Tayside and Perth & Kinross IJB that continuity of managerial responsibility and professional leadership of Mental Health will be maintained, that oversight of the HSE action plan will continue and that clarity as regards accountability within the new hosting arrangement will be reached as soon as possible
- The performance review process for Mental Health was discussed and a resolution of the difficulties is being actively pursued. The Medical Director advised that an update would be provided in the Mental Health risk assurance report at the next meeting.

Horizon Scanning

- The Medical Director commended the outcomes of the Donation Committee, that NHS Tayside adopted an impressive holistic approach to organ donation. It was noted that the Scottish Government is forming legislation in regard to a 'soft opt out' system for organ donation, similar to that which is in place in Wales
  The Medical Director advised that next CQF in September 2016 would see agreement of the refreshed Terms of Reference and membership.
- During discussion of 'PRI patient flow **-** performance against key measures', it was noted how the risk stratification score had been used to review and reduce the risk exposure rating and that it would be possible to undertake a similar exercise for Ninewells Hospital, if resources were available.

Delegated Decisions taken by the Committee

- The Committee was updated on 'PRI patient flow - performance against key measures' and noted that in June 2016, the score across all metrics was 7 (green), a very positive score. They requested an update at each meeting.
- The Committee requested a report from the new Mental Health Accountable Officer at its next meeting in November 2016.
- The Committee discussed the Scottish Public Services Ombudsman report and the learning outcomes for NHS Tayside, requested additional information regarding the current status of learning outcomes relating to the complaints and requested that future reports to the Committee contain information on Procurator Fiscal reviews and recommendations following FAI outcomes

Alison Rogers
Clinical and Care Governance Committee Chairman

October 2016

Item 6.3

BOARD103/2016
Tayside NHS Board
27 October 2016

Formatted: Font: 11 pt

Formatted: Font: 12 pt

COMMITTEE CHAIR'S ASSURANCE REPORT

FINANCE & RESOURCES COMMITTEE

Formatted: Font: 12 pt

Thursday 18 August 2016

Performance Against Workplan

At the meeting held on 18 August 2016 the Committee received the Additional Cost of Teaching (ACT) Annual Update Report and the Property Asset Management Strategy (PAMS) update. It also considered the Capital and Corporate Financial reports, scrutinised the corporate risks assigned to the Committee and noted the details of contracts awarded in excess of £150k. The following matters are highlighted for the attention of the Board:

Formatted: Font: 11 pt

Formatted: Line spacing: single

- ACT received funding in excess of £12m from NES in 2015/16. NES monitors effective use of resources it allocates and it was reported that NHS Tayside were the only Medical School in Scotland where no red flags had been received for 2015/16. Dr Ibrahim who prepared the report was confident that all funding received from NES would be justified. It was noted however that NHS Tayside still require to outsource students due to the lack of capacity within NHS Tayside.
- At 30 June 2016, the 2016/17 forecast capital expenditure is in line with the 2016/17 LDP forecast spend profile. Scottish Government are making £100m available to create and support employment. NHS Tayside are submitting bids to secure a level of this additional funding. It is critical that planning of capital projects is coordinated and profiled to ensure the required infrastructure is in place to support larger high profile capital projects such as those funded through the Archie Foundation. Due to the scarcity of capital it is also important that sufficient funding is allocated to maintain assets which are likely to be used well beyond their original anticipated lifespan.
- The position relating to revenue is less encouraging with a deficit of £4.48m reported for the first quarter. This is a deterioration of £1.6m against the previous month. It was noted that none of the Board Contingency had been applied at this stage to offset the overspend, however it is clear that the rate of spend is such that the LDP figure of £11.7m will be breached unless sustained action is taken to address the

Formatted: Font: 11 pt

areas of overspend. The Committee amended the recommendation in the report to stress that the actions taken by Management must contain spend rather than "wherever practical" as suggested in the report. Members also requested more information in respect of the risks associated with IJBs not meeting their savings targets. A new format of financial report was presented to the Committee and there was general agreement that this improved transparency and assisted members in gaining a clear understanding of the financial challenges facing the organisation.

- It was recognised that PAMS must be led by the Board's Clinical Strategy and be consistent with all other supporting strategies. All 53 sites were subjected to the Scottish Government's Statutory Compliance Audit Reporting Tool and it was noted NHS Tayside recorded an overall compliance rate of 48% against the Tool. The PAMS Update Report highlighted the key elements to be addressed to comply with the Scottish Government's requirements. It was noted that there has been a significant increase in backlog expenditure, rising from £60m to £100m. The Committee noted many of NHS Tayside's properties were ageing and there was a legacy of critical investment required. Any capital monies allocated to the Property department will be prioritised to address statutory compliance infrastructure issues.

Update on Risks

There are three strategic risks which fall under the scrutiny of the Finance & Resources Committee. The evaluation of one of these risks has changed from the position reported to the last Board. It is important to record and consider the current evaluation of these risks:

- The first relates to failure to deliver the Strategic Financial Plan and the impact this would have on delivery of national and local plans and the potential to breach the statutory financial obligations of the Board.
  - The current score for this risk remains at 25 (very high) which is the same score as the inherent risk. This reflects the current significant financial challenges the Board faces and the required timescale for returning the Board to financial balance.

- The second strategic risk relates to the reduction in capital resources experienced by the Board and the impact this has on our ability to deliver the Clinical Strategy and the Property Asset Management Strategy.
  - The current score for this risk has been reduced to 16 (high) against an inherent risk score of 20. This is a reduction from the score of 20 previously reported. The revised score reflects the controls in place and an awareness of the current constraints nationally on capital resources.

- The third strategic risk relates to Information Governance and the impact any failure to comply with legislation and standards would have on the Board's reputation, public trust and potential financial loss.
  - The current score for this risk remains at 12 (high) against an inherent risk score of 25. This reflects the Board's current strength in this area in terms of corporate governance and management arrangements including adherence to legislation and policies, but recognises there are still critical pieces of work to complete. It is important that the Board retains focus on this important subject and that key roles remain adequately resourced. Plans are in place to reduce the risk score to 9 (medium).

Delegated Decisions taken by the Committee

Formatted: Font: 11 pt

Formatted: Indent: Left: 0.5", Line spacing: single, No bullets or numbering

Formatted: Line spacing: single

Formatted: Font: 11 pt

- Recommended the submission of the full business case for the NHS Scotland Pharmaceutical 'Specials' Service Project to the Tayside NHS Board at its meeting on 25 August 2016 for approval prior to submission to the Scottish Government Capital Investment Group.

Any Other Major Issues to highlight to the Board

Formatted: Font: 11 pt

Early indications are that the July figures will add a further £1.1m to the revenue deficit. It is clear that unless sustained and accelerated action is taken the Board is at risk of breaching the financial targets set out in the LDP. The Committee seeks assurance from the Board and the Transformation Programme Board that there is sufficient traction and pace around the actions identified to achieve savings.

Formatted: Line spacing: single

- The Committee requested NHS Tayside approach Perth & Kinross Council and Perth Integrated Joint Board regarding purchasing the vacant property at Aberfeldy for the purpose of nursing accommodation. This was subsequently raised at the Transformation Programme Board and assurance was given that it was normal practice to 'trawl' other public bodies before marketing properties for sale on the open market. It was confirmed this would include Perth & Kinross Council.

Horizon Scanning

- It is now known that the Board's accounts for 2015/16 are the subject of a Section 22 Report by the Auditor General. It is likely the Board will be asked to respond to the Auditor General's findings including information on the current cost of the Board's operating model and how the Board intends to return to a financially balanced position.
- A meeting has been arranged for mid-November between the Chairs and Lead Officers of the Finance & Resources and Staff Governance Committees to discuss cross-cutting issues and to develop a coordinated approach to issues of mutual interest.

Doug Cross
Finance & Resources Committee Chairman
20 October 2016

Item 6.4

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

BOARD104/2016
Tayside NHS Board
27 October 2016

COMMITTEE CHAIR'S ASSURANCE REPORT

STAFF GOVERNANCE COMMITTEE

27 September 2016

Performance against workplan

Action Points

Verbal Update given to Committee about '*Supporting Staff who are Carers*' work that was received positively by the committee and also Carers Positive Award that organisation subsequently received, appreciating examples such as this that focused upon assisting staff and improving the staff experience within NHS Tayside.

Chairs Assurance Report 21 June 2016

I had commented that "*Disappointment that for the second year in a row that the committee were unable to gain assurance that the Local Monitoring Returns were reviewed effectively in partnership for the majority of directorates…the organisation should work hard to ensure the partnership structures are effective at the LPF (Local Partnership Fora) level*."

To note that staff feeling **Involved in Decisions** was also the lowest marked of the key areas in iMatter staff returns to date. To confirm that I attended an event with the Co-chairs of LPFs on 27/9/2016 led by the Employee Director & Director of HR & OD and was able to gain more assurance of the commitment to LPFs and partnership working. The committee will continue to monitor this area closely.

Presentation

Non-Executive Members presented on NHS Tayside Recognition Scheme Awards – NHS Tayside STAR awards. This will provide staff and members of the public the opportunity to nominate staff in a range of award categories. Planned launch in May 2017, welcomed by committee members.

NHS Tayside Statutory/Mandatory Training Agenda

Committee agreed the following 9 core areas to be prioritised, following national and local work carried out. This was following concerns raised about the no. of training courses, duplication and lack of clarity raised at previous meetings following Pilot work. The 9 areas are:

- **Equality, Diversity & Human Rights • Health, Safety and Welfare • Fire Safety • Infection Prevention and Control • Manual Handling • Violence and Aggression (Personal Safety Awareness) • Information Governance • Public Protection (includes Adult and Child Protection) • Resuscitation (summoning clinical assistance)**

In relation to future reporting of activity against this, the committee agreed that requests would go to APF (Area Partnership Forum) who will in turn seek assurance locally from Local Partnership Fora Co-chairs.

From the activity report, Violence & Aggression & HAI were the two areas picked out by the committee with a lowest no. of staff completions. Also further reports should include, as well as number of staff completing, more qualitative information about the impact made through the training.

In relation to a query about no. of staff having had their Flu vaccine being lowest in NHST against other Health Boards, it was noted that work was being done around this and the Clinical Committee was where the assurance reporting around improvements in this regards was being reported.

Board Members Input into Programme of Welcome Events for New Employees

This was welcomed by the committee, the proposals will come to the Staff Governance Committee in March 2017 as by this time the 'Discovery Phase' of the Cultural Diagnostic Kings Fund Toolkit will be complete and learning can be incorporated.

<u>Update on Risks</u>

Medical Workforce

No change in the medical workforce risk scoring, still Very High and a Red Risk at 20. No sign of this risk reducing and expected to be a strategic high risk for the organisation into the future. A number of actions to reduce the risk, with a note that in future reporting the following emergent themes will be considered such as –

- Announcement of a National Workforce Plan for Scotland
- Balance of patient safety and budgetary control responsibility of the Directors
- Risk to be reviewed to ensure accurately reflects the full scope and impact of this risk e.g. to cover recruitment and retention of all grades of medical staff, development opportunities incl. appraisal roles.

- Additional operational risks to be considered and articulated to support the mitigation of this strategic risk.

Workforce Optimisation

Risk now High at 16 – from 12 (Possible – may occur occasionally to now Likely – could occur several times)

The reason for this is that projected savings in relation to workforce to achieve financial balance are now taking longer to be realised in the current financial year. An additional control that has been put in place with the objective to standardise shift lengths and patterns, thus realising nursing staff to be deployed in accordance with NHST rostering policy. A new 3 month risk review date will be added following the meeting of the Staff Governance Committee.

Nursing Workforce

This risk is still very high and like Medical Workforce a significant risk for the organisation. Some examples of actions that have taken place are noted below:

Recruitment

NHS Tayside engaged with 3 local Universities (Dundee, Abertay and Robert Gordon) to proactively recruit Nursing and Midwifery graduates who will Register with Nursing & Midwifery Council September – October 2016. To date 212 Newly Qualified Practitioners have been recruited, this includes

140 Adult Nurses
45 Mental Health Nurses
6 Paediatric Nurses
21 Midwifes

eRostering
The implementation of eRostering is progressing in line with approved project plan.
The implementation of Safe Care has commenced with all Ninewells and PRI inpatient areas to be implemented by January 2017.

Workforce Information Report Q1 2016/17

With regard to issues raised by staff side colleagues in relation to the accuracy of the reporting of disciplinary cases, grievances, bullying and harassment and attendance dismissals, HR and Staff side colleagues met to discuss the methodology of reporting and the collation of data. It has been agreed that information will be provided for the Local Partnership Fora to discuss and this will provide a local platform for confidential discussion around the trends identified in relation to the aforementioned categories

Also clarity requested on report for the reasons behind the jump in headcount for Perth & Kinross IJB from 1/4/16 to end of first quarter 2016/17.

Future Assurance Reporting – IMATTER

Paper received and supported that following Area Partnership Forum meeting discussions that the Local Partnership Fora will have a key responsibility around the outcomes of IMATTER for their specific directorates.

Promoting Attendance: Quarter 1 – 2016-17 Report

Sustained improvement noticed for areas that the committee has highlighted in past. It was noted that Perth & Kinross IJB, Surgery/Theatres & Communities were current areas that a closer look would need to be undertaken to ensure stability in attendance rates.

Occupational DNA rate, whilst still high at 11.1% (July-Sept 2016), this is an improvement on the rate from April - June 2016, 15.6%, the committee will continue to receive reporting of this rate and the reducing DNA rate, if continues, is welcomed.

Staff Governance Report: Recruitment Activity

Mental Health vacancy rate at 14.55% was very high and an improvement plan for this area was requested as part of the update to the Recruitment & Attraction Strategy, which is due in December 2016 to the committee. Also in discussion, it was requested that work be done in assuring the committee around the recruitment & selection processes for Newly Qualified nurses, were effective and smooth as possible, following anecdotal evidence and feedback received from some committee members.

Also worth to note, that Perth Royal Infirmary presents a significant challenge for recruitment. Hard to fill vacancies include registered nurses within Medicine, Orthopaedics and Surgery and difficulty in recruiting to Radiography.

Pharmacy technicians (2 x band 4 permanent full time) to the Prison Service have also remained unfilled for over 6 months.

Registered nurses (band 5) Orthopaedics at Ninewells

Whilst within the Medical and Dental job family, the key hard to fill medical posts are Psychiatry posts across all specialties and grades.

Staff Experience & Engagement, Embedding IMATTER as a vehicle to underpin an Improvement Culture

It was noted that there was agreement at the Area Partnership Forum in 2015, that to ensure appropriate local governance, responsibility to support, nurture and embrace the opportunities that iMatter will provide to teams and service's that accountability will sit with the Local Partnership Forums reporting progress, recognition and celebration in to Staff Governance Committee and the Area Partnership Forum. The other prime responsibilities of the Partnership Forums will be focused on monitoring implementation, creating readiness and positively supporting staff engagement whilst celebrating and addressing emergent Directorate themes. The Staff Governance Committee through the Area Partnership Forum

will require reports from these forums directly. Therefore the Area Partnership Forum should seek details on implementation and progress of improvement and development from within each Directorate from the Co-Chairs of the Local Partnership Fora including progress on addressing emergent generic themes and communication and engagement within the associated Directorate.

Arrangements for governance of the Health & Social Care Partnership reports will be confirmed once the cohorts for each area have been confirmed, i.e. whether implementation will cover Local Authority staff as well as NHS-employed staff.

The amount of work that has been carried out to date should be celebrated, including the amount of engagement with staff. For example Support Services, an area of the organisation that has had really low response rates within past Staff Surveys and a key part of the organisation that it is important to engage with, is showing nearly triple response rates in iMATTER, with paper responses still to be counted.

The challenges for NHS Tayside around iMATTER are noted by me in the Any other Major Issues to highlight to the Board Section.

Public Sector Equality Duty Measures

Noted in Any other Major Issues to highlight to the Board Section

Exit Questionnaires

Will continue within Board, results show, main reasons for leaving current post as Career Progression 27.1%, Family & Personal Reasons 15.8% and Retirement 15.8%.
It was noted that 2.9% of leavers had noted Bullying/Harassment as the reason for leaving and 0% Discrimination. Other was high at 17%.

Other – the most common reason within this at 27.5% is relocation

The Exit Questionnaire was introduced in 1 April 2015 and 264 people have completed to date. The committee asked for the numbers completing to be compared to total leavers for future reports.

Delegated Decisions taken by the Committee

Statutory/Mandatory Training – Approved 9 core areas as noted above and future assurance reporting.

IMATTER – Approved and future reporting for assurance via Local Partnership Fora as noted above.

Fixed Term Policy Updated Aug 2016 approved

Any Other Major Issues to highlight to the Board

IMATTER

As stated IMATTER has been an effective process for engaging staff across the organisation and should be celebrated. Although all cohorts have not completed yet, there are some teams that have returns for both 2015 and 2016, thus some comparisons can start to be made for the organisation at this stage. The concerning factor is that three areas for improvement that I have mentioned in my Board update last year are still not showing improvement and are still proving challenging for the organisation and I have noted these below.

I am confident performance is managed well within my organisation (Performance Management) is still at 60%. This is a cause for concern; an improvement plan is currently underway with a target measure to improve compliance of e-KSF and PDPs to 80% by December 2016.

This is an item that has been raised by me to the Board before, thus after December 2016 dependent on the final outcomes of the eKSF improvement plan and outcomes, the Board will need to decide on decisions to take in relation to this measure going into the future. Although the e-KSF system is bureaucratic and issues have been raised with the system including at National Level. As a governance committee we need to ensure that staff have a clear understanding of their role and the part they are able to play within their team and organisation, ensuring that they have a clear set of priorities and objectives in their work and also importantly are having these discussions with their line manager and possessing and applying the knowledge and skills they need to perform that role effectively and to achieve their objectives.

Also mentioned in past updates as an issue has been senior management visibility, again this has deteriorated. **I have confidence and trust in senior managers responsible for the wider organisation has went down from 62% to 59%**. It was requested that the Chief Executive give an update on the leadership work that is being undertaken and this has been postponed until December 2016. Also **I feel senior managers responsible for the wider organisation are sufficiently visible has also moved from 59% to 56%**

Staff feeling involved in decisions is also lower now. I have somewhat more assurance following the Local Partnership Fora co-chairs meeting that I attended and commitment shown from Employee Director and Director of HR & OD to work hard to improve this and also following more assurance reporting via Area Partnership Forum and Local Partnership Fora. **I feel involved in decisions relating to my organisation (Partnership Working) is moved from 54% to 52%**

Public Sector Equality Duty Measures

I was also concerned with Measure 2 for this, we have asked for improvement in relation to the % of panels which have a panel member who has attended the Certificate to Recruit. This gives us assurance that we have a reliable system in relation to recruitment & selection. Whilst there has been improvement from a very low **12% in January 2015** to **53% in June**

2016, I noted some areas of the organisation which were really low within the most recent results reported – i.e. Corporate/Board 34% and Operations, Medicine & Mental Health at 38% and Perth & Kinross at 47%, against 93% in Angus.

The Director of HR&OD asked that a report come back to the next meeting with the planned trajectory, dependent on this the committee will have to make a decision.

Horizon Scanning

People Matter Strategic Framework is a critical document which the committee had signed off previously. The requirement to deliver Everyone Matters will rest on the organisation being able to fully deliver the key objectives as outlined within the document. As part of the refreshed Terms of Reference for the Staff Governance Committee that will come in December 2016, a proposal is to have a 'People Matter Strategic Group' that will monitor delivery of the action plan and report progress to the Staff Governance Committee.

With future assurance reporting highlighted and within this the Local Partnership Fora having a critical role to ensure outcomes are being met and reported up through the Area Partnership Forum, it is expected that the challenges as noted within IMATTER by staff will improve, the committee will monitor progress closely.

In clear terms the clear strategic challenges that the Board will have to take cognisance of is – **Recruitment** as per the red risks within Medical & Nursing and increasingly Workforce Optimisation; **IMATTER staff results** – senior management visibility, performance appraisals and staff feeling sufficiently involved in decisions are areas marked lower. Actions are underway in all of these however it is fair to say that progress and evidence of improvement has been slow. Health & Safety is also an issue that has undergone organisational changes recently and via Staff Governance Standard performance updates it is expected that reporting will improve.

Also with a commitment that Local Partnership Fora understand their remit and are clear about the critical role they have in assurance reporting, we can hopefully have more confidence in future returns i.e. **Staff Monitoring Return** and **Workforce Plans** and in particular that these documents have been generated from a bottom up and consultative process in partnership. Also as the Terms of Reference is refreshed for December 2016, it is likely that the use and cost of temporary staff employed by the Board (i.e. bank and agency nurses and doctors) will come to the Staff Governance Committee now as well as just the Finance & Resources Committee for assurance.

Munwar Hussain
Staff Governance Committee Chairman
October 2016

Item 7.1

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

BOARD105/2016
Tayside NHS Board
27 October 2016

SHAPING SURGICAL SERVICE (SSS)

1. PURPOSE OF THE REPORT

The purpose of this report is to present the Outline Business Case (OBC) for Shaping Surgical Services and advise NHS Tayside Board of the outcome of the Options Appraisal which identified the most high quality, person centred, safe, effective sustainable service model that can be delivered within available resources to optimise surgical services if approved.

2. RECOMMENDATIONS

The Board is asked to:

1. Note the content of the Executive Summary and Outline Business Case.
2. Endorse the recommendation to progress to a single site acute receiving unit on the Ninewells Hospital site ensuring that:
   a) all NHS Tayside patients have access to a dedicated specialist surgical acute receiving unit and 24/7 CEPOD Theatre (emergency theatre)
   b) major elective general surgery is increased on the PRI site increasing the number of patients who can be treated locally, whilst increasing productivity, efficiency and timeliness of elective surgery for Tayside patients
3. Note Stracathro Hospital will continue to be an integral component of the elective care model for NHS Tayside for patients who meet the criteria for surgical intervention on the site
4. A consultation document is being prepared for submission in anticipation that this will be regarded be major service change that planning is underway to progress to a three month formal public consultation on the preferred option as above in line with Scottish Government CEL 4 (2010) guidance

3. EXECUTIVE SUMMARY

This paper case provides an overview of the key messages within the Shaping Surgical Services Outline Business Case and supporting documents which provides NHS Tayside Board members with a recommendation for the way forward. The business case draws attention to the current surgical service configuration, the two preferred options following an options appraisal and the implications of these two options for patients, staff and NHS Tayside.

An Executive Summary is provided at beginning of the OBC.

4. REPORT DETAIL

SSS programme of redesign was established in 2014 with the aim of undertaking a comprehensive whole system review across the Tayside general surgery service to ensure the provision of sustainable high quality, person centred, safe, effective and affordable surgical services.

The OBC attached with this report provides the full detail of the programme to date.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

The SSS programme is a clinically led managerially facilitated service redesign is fully aligned with the comprehensive five year Strategic Transformation Programme.

The aims of SSS map over to the Transformation Programme to ensure service redesign changes support progression to the following outcomes:-

1. Improving patient outcomes, quality and safety
2. Cost effective service delivery
3. Sustainable financial balance

Previous Board papers have highlighted that NHS Tayside has an operating service model that extends beyond its budgeted financial allocation in terms of site configuration, workforce, medicines, and operational costs.

The SSS programme is underpinned by NHS Tayside aims and objectives in ensuring that service delivery is high quality, person-centred, safe and effective and is in line with the organisational vision that: ***"Everyone has the best care experience possible".***

6. MEASURES FOR IMPROVEMENT

Unscheduled care

- Timely access to a fully staffed emergency theatre
- Compliance with Acute Care standards (2010)
- Comprehensive assessment before admission to ensure most appropriate care
- Compliance against Emergency theatre classification framework
- Reduce post operative readmission
- Contribute to reduced longs lengths of stay (LOS)
- Operations that are carried out at night meet NCEPOD classifications and be under the direct supervision of a consultant surgeon.
- Critical care occupancy rate of 70% of the staffed beds (SICSAG, 2012)

Scheduled Care

- Improved patient experience & quality of care
- Increased elective care closer to patients home
- Reduction in unutilised theatre hours/unallocated theatre hours
- Reduction in cancellation of elective surgery
- Reduction in emergency cases in planned sessions
- Delivery of Treatment Time Guarantee (TTG) & Cancer Targets

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

Since its launch at the start of April 2014, Shaping Surgical Services has engaged with a wide

range of stakeholder groups within primary and secondary care. Numerous engagement events have been held with staff, members of NHS Tayside public partner group and Scottish Health Council.
There is a dedicated communication and engagement group chaired by NHS Tayside Board Secretary which has in place a Communications and Engagement Plan which tracks all stakeholder engagement and sets out the ways in which stakeholders will be involved, engaged and informed about the SSS programme of work.

8. PATIENT EXPERIENCE

Following approval of the recommended option we will conduct a full Equality and Diversity Impact Assessment alongside wider public consultation.

9. RESOURCE IMPLICATIONS

The Board is asked to note that a detailed financial appraisal will be undertaken during the period of consultation which follows approval of the recommended option. This appraisal will build on the detailed service review already undertaken, and will include confirmation of workforce models, support services and any reconfiguration costs. High level financial implications suggest status quo current costs will remain with no improvement in quality of service provision; Option 1 has opportunity for improved quality, service efficiency and cost reduction; Option 2 has no reduction in cost base and requires significant investment in workforce and infrastructure.

The recommended option and related costs, will reflect a move to upper quartile performance in relation to the following key performance indicators:

- Average length of stay (elective and emergency)
- Pre-Operative length of stay
- Cancelled elective procedures
- Treatment Time Guarantee

This is consistent with a number of current initiatives within the Transformation Programme, in particular the Realistic Medicine Work Stream.

10. RISK ASSESSMENT

There are four key areas within NHS Tayside strategic risk profile that the SSS recommended option has the potential to significantly reduce the risk exposure rating. These are:

- HEAT Targets for patients requiring elective surgery
- Medical & Nursing Workforce
- Capacity and Flow
- Financial Performance

11. LEGAL IMPLICATION

This work will support compliance with the Treatment Time Guarantee legislation.

12. INFORMATION TECHNOLOGY IMPLICATIONS

There are no known IT implications that are not already being addressed as part of NHS Tayside E-Health Plan

13. HEALTH & SAFETY IMPLICATIONS

There are no known Health and Safety Implications with the recommended option.

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no healthcare associated infection implications with the recommended option
There is clinical evidence that 'ring fenced' elective surgery beds will contribute to effective prevention and control and Surgical Site Infection rates.

15. DELEGATION LEVEL

Chief Operating Officer – Executive Lead / Sponsor
General Manager Surgery – Operational Lead
Associate Medical Director Surgery – Lead Clinical Officer

16. TIMETABLE FOR IMPLEMENTATION

Programme Timetable 2014-2017

Milestone	***Complete Target Date***
Building the options	April 2014 to August 2014
Options Appraisal	26 June 2015
Approval from CEO & NHS Tayside Board to progress to data collection on preferred options & engagement period	July 2015- September 2015
Data collection & evidence base case for change	September 16 to December 2016
Stakeholder engagement on case for change	January to March 2016
Building the Outline Business Case	March – July 2016
Stakeholder engagement on options	August- October 2016
Submission of Outline Business Case to NHS Tayside Board	**26 October 2016**
Consultation & Engagement (Three months)	November 2016- January 2017 (indicative but will be three months as a minimum)
Submission of Full Business Case to NHS Tayside Board	**March 2017**
Notification of Decision	April 2017
Initiation of Project Implementation	TBC
Phase 1 Service Design Changes	TBC
Phase 2 Recruitment and Training / Development	TBC
Phase 3 Initiation of activity	**July 2017- October 2017**
Review of Performance (PPE)	November 2017

17. REPORT SIGN OFF

Ms L Wiggin
Chief Operating Officer

Ms L McLay
Chief Executive

Dr A Cook
Medical Director, Operational Unit

18. SUPPORTING DOCUMENTS

Shaping Surgical Services	Executive Summary & Outline Business Case
Shaping Surgical Services	Communication & Engagement Plan
Shaping Surgical Services	Options Appraisal

Shaping Surgical Services (SSS)

Service Improvement Outline Business Case (OBC)

Date: 27 October 2016

List of Contributors

Name	Designation
Tracey Williams (author)	Associate Director Improvement
Arlene Wood (author)	General Manager , Surgery
Professor Peter Stonebridge (author)	Associate Medical Director ,Surgery & IHO Clinical Lead
Mr Philip McLoughlin	Former Associate Medical Director, Surgery
Dr Gavin Main	Associate Medical Director , Access and Consultant Radiologist
Lorna Wiggin	Chief Operating Officer
Dr Eddie Wilson	Clinical Director, Anaesthetics & Critical Care
Mr John Nagy	Clinical Director ,Surgery
Alastair Adam	Clinical Services Manager, Theatres & Anaesthetics
Lynn McAteer	Head of Nursing, Surgery
Santosh Chima	Diversity & Inclusion Manager
Allyson Angus	Public Participation Manager
Karen Kidd	Senior Finance Manager
Carol Angus	Health Intelligence Analyst
Russell Goldsmith	Health Intelligence Officer
Sarah Lowry	Business Unit Team leader
Tom Jarosz-Cromie	Capacity Planning Programme Manager
Kenny Scott	Business Intelligence Lead (Surgery)
James Henderson	Transformation Programme Lead
Elizabeth Henderson	Clinical Service Manager , surgery
Judith Golden	Employee Director
Kenny Freeburn	Scottish Ambulance Service, Head of Ambulance Services Tayside

Number	Contents	Page number
	Executive summary	5
	Part 1- Strategic Case for Systemic Change	
1.1	Introduction	20
1.2	Background	21
1.3	Strategic Context	21
1.4	Vision	23
1.5	Scope	23
1.6	NHS Tayside Catchment Area and Population	23
1.7	Health Inequalities	24
	- Key Messages	26
1.8	NHS Tayside Overview	26
1.9	In Scope – Service Overview and Current State / Status Quo	26
1.10	Demand for Surgical Services	29
	Part 2 -Case for change – Clinical and Economic	
2.0	The Case for Change – Scope and Nature of Care	31
2.1	Service Gap	33
2.2	Maintaining Safe and Sustainable Workforce	33
	- Workforce	33
	- Training and Education	35
2.3	Delivering Treatment Time Guarantee	35
2.4	Separating Scheduled and Unscheduled Care	37
	- Unscheduled Surgery (Emergency)	37
	- Access	40
	- Elective Surgery	40
	- Institute of Healthcare Optimization (IHO)	41
2.5	Maintaining / Supporting Infrastructure for Delivery of Elective and Unscheduled Surgery	42
2.6	Summary	43
2.7	Measures of Success	44
	- Unscheduled Care	44
	- Scheduled Care	45
2.8	Economic Case	45
2.9	The Long List of Options	48
2.10	The Short List of Options	49
2.11	Benefits Criteria	50
2.12	Weighting Criteria	51
2.13	The Options Appraisal	51
2.14	Scoring the Options	52
2.15	Summary of Ranking and Weighting of Options	52
	Part 3 - Change Proposal & Recommendation	
3.0	Option 1 Overview	54
3.1	- Unscheduled Care	56
	- Elective Care	57
	- Workforce	57
	- Patient Experience	57
	- Key messages	59

3.2	Option 2 Overview	60
3.3	- Unscheduled Care	61
	- Elective Care	63
	- Workforce	63
	- Patient Experience	63
	- Key messages	64
3.4	Feasibility Assessment	65
3.5	Informing, Engaging & Involving	67
	- The Communications and Engagement Approach	67
	- Communication and Engagement – Next Steps	69
	- Equality & Diversity Impact Assessment (EQIA)	69
3.6	Financial and Economic Impact	70
	- Current State – Option 1	71
	- Current State – Option 2	71
3.7	Risk Analysis	72
	- Programme Management Risk Assessment and Analysis	72
	- Programme Timetable 2014 - 2017	73
3.8	Management Case	74
	- Project Management Arrangements	74
	- Project Controls	75
	- Delivery Phase	76
	- Review Process	76
3.9	Conclusion and recommendations	77

Executive Summary Shaping Surgical Services

The following outline business case summarises the current delivery of surgical unscheduled and elective care related to the provision of all General Surgery (including Upper Gastrointestinal, Lower Gastrointestinal, Hepato-Billiary, Vascular Surgery and Urology) within NHS Tayside. The paper covers relevant National Guidelines and Standards and brings together the recent work undertaken by NHS Tayside under the auspices of Shaping Surgical Services (SSS) and the Institute of Healthcare Optimization (IHO).

The scope of Shaping Surgical Services comprises of General Surgery which includes colorectal, Hepato-Billiary and Upper Gastro Intestinal surgery, Urology, and Vascular Surgery specialities. More specifically the element of the patient pathway under consideration is the adult in-patient peri-operative phase of elective and unscheduled (emergency) surgery.

For clarity, elective surgery is surgery that is planned in advance whereas emergency surgery is unscheduled with patients referred by their GP/Consultant or through self presentation at A&E services or through 999 response services. The context of emergency surgery for the purpose of the document will be referred to as unscheduled, and in any wider public engagement. This is because emergency care encompasses a wide spectrum of cases and not all unscheduled care is a 'surgical emergency' ([1]Patton & Thakore, 2013).

Service provision within specialist surgical services and paediatric surgery are not in scope nor is outpatient or diagnostic services. The scope relates to services across our 3 acute hospital sites in NHS Tayside: Perth Royal Infirmary (PRI), Ninewells (NWH) and Stracathro (SRTC).

One of the Health Board's key objectives is to be an organisation that continually strives to improve patient experience and outcomes. This work represents the commitment of the clinicians, managers and others to ensure surgical services are safe, effective and sustainable for future population and patient needs.

This case highlights concerns regarding the current configuration of services and sets out two options for the reconfiguration of a core clinical surgical service.

Background

Patients requiring unscheduled surgical care are amongst the sickest patients treated in hospitals. Effective and efficient delivery of unscheduled surgical care depends on a number of key elements (clinical assessment, radiology, theatres, and critical care) which require teams of experienced clinical staff (Medical, Nursing and Allied Health Professionals) working together to provide the best outcomes for patients.

The National Audit Office for England and Wales reported that unscheduled admissions across all specialities have increased by 47% over the last 15 years[2]. Given that

[1] Patton, G., & Thakore, S. (2013). *Reducing inappropriate emergency department attendances-a review of ambulance service attendances at a regional teaching hospital in Scotland*. *Emergency Medicine Journal*, *30*(6), 459-461. DOI: 10.1136/emermed-2012-201116

[2] Emergency admissions to hospital: managing the demand, National Audit Office, 2013

unscheduled anaesthesia and surgery make up an estimated 40–50% of the surgical workload in the UK ([3]Royal College of Anaesthetists, 2014), there has been a steady build-up of pressure on the delivery of unscheduled care for surgical patients.

Poorly delivered unscheduled surgical services have a number of consequences. First and foremost is the adverse impact on patients as a consequence of complications, returns to theatre and increased length of stay. This in turn may lead to poor quality of life, morbidity and even mortality. There is also a consequence to social services through the increased need for rehabilitation and welfare support. All these issues increase costs to the NHS and to society in general.

Delays in treating unscheduled surgical patients can also result in additional complications and higher mortality. It must be recognised that rapid access to imaging and access to a fully staffed and resourced theatre for those patients requiring immediate intervention, will not only be safer for patients but will be cost effective in the longer term.

Maintaining and improving safe, sustainable and high quality unscheduled care is the primary goal driving the SSS Services work programme and the proposed reconfiguration of hospital services.

Available Standards, Guidelines and Evidence

There have been a number of reports concerning the provision of unscheduled surgical care and service reconfiguration in the last few years; [4] Royal College of Surgeons (RCS) (2011) '*Emergency Surgery: Standards of unscheduled surgical care, Guidance for providers, commissioners and service planners*' and [5]*'Issues in Professional Practice: Emergency General Surgery*', Association of Surgeons of Great Britain and Ireland (ASGBI), (2012). The [6]King's Fund (2014) also published an evidence guide *'The Reconfiguration of Clinical Services: What is the evidence?* This covered a number of services including 'Acute surgical services' in pages 50-54. There was also a further 'briefing' by the [7]King's Fund in 2014; '*Reconfiguring hospital services'.*

On a broader theme in Scotland the Chief Medical Officer's Annual Report [8]2014-15 '*Realistic Medicine'* encompasses many of the broader themes running through the issues surrounding the challenges related to the provision of surgical services. The report described a [9]'House of Care' model, the most pertinent part being that organisational processes and arrangements are built on a foundation of responsive allocation of resources. In other words: the highest possible care within an efficient cost framework. More specifically there were concerns in the report about variations in the practice and provision of services. This in turn may affect the management of risk that such differences may cause. Finally there was a specific call to change practice to support improvement; these:

'....*are often dependent upon having the right conditions in place*'.

The other key principles and messages from these reports are outlined in the sections below.

Service Development

---

[3] Royal College of Anaesthetists (2014). *Guidelines for the provision of anaesthetic services*.
London: Royal College of Anaesthetists. Available at: www.rcoa.ac.uk/system/files/GPAS-2014-FULL_0.pdf
[4] *Emergency Surgery: Standards of unscheduled surgical care, Guidance for providers, commissioners and service planners*', Royal College of Surgeons of England (RCS), February 2011,
[5] *'Issues in Professional Practice: Emergency General Surgery*', Association of Surgeons of Great Britain and Ireland. May 2012
[6] The King's Fund (2014) *'The Reconfiguration of Clinical Services: What is the evidence?*' .
[7] www.**kingsfund**.org.uk/publications/**briefings**/the_2.html
[8] Realistic Medicine. Chief Medical Officer's Annual Report 2015/16. Http://www.gov.scot/Resource/0049/00492520.pdf
[9] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf
The house of care metaphor is used to illustrate the whole-system approach, emphasising the interdependency of each part and the various components that need to be in place to hold it together. www.kingsfund.org.uk/.../delivering-better-services-for-people-with-long- term-conditions.pdf.

In any reconfiguration of hospital services there are four interlinked drivers: quality & safety, workforce, access and cost. The challenge is to arrive at a configuration that optimises all these elements, as far as this is possible given the complex trade-offs that exist between them and the need to balance resources across unscheduled and elective care in order to achieve the highest quality of care. Quality considerations include timely access to highly trained professionals in all disciplines, compliance with clinical guidelines, access to diagnostic and interventional technologies, access to other support services and strong clinical governance. For some conditions, the time it takes to access these services will also be an indicator of quality.

Quality and Clinical Improvement

The [10]King's Fund (2014) summarised the evidence:

'*Acute surgical services should be supported by a dedicated emergency theatre, appropriate critical care services, acute medicine and diagnostic services, including interventional radiology.*

Outcomes for unscheduled surgery vary considerably between units. There is some evidence that hospitals who conduct higher volumes of surgery have better outcomes.*'*[11] [12]*(*Urbach and Baxter 2004, Naylor, 2013), though the relationship is quite complex.

On a similar vein, the Presidents of [13]The Academy of Medical Royal Colleges (2010) stated that:

'… there is increasing recognition that services such as emergency surgery may be unsafe out of hours and the provision of these services needs to be concentrated in fewer centres.'

[14]The RCS report (2013), '*Reshaping surgical services: principles for change'* reiterated that '*where possible, major emergencies are centralised'.*

The key resources needed for effective management of unscheduled surgery derived from the above reports are summarised below:

• Acute Surgical Receiving Unit providing focused, streamlined resuscitation and assessment.
• Separate unscheduled and elective services and beds.
• Adequate theatre access: real, prioritised and staffed. Undertaking 'unscheduled operations' at any time, day or night.
• Adequate senior availability within job plans.
• Surgeons with adequate skill sets.
• Adequately staffed junior team.
• On-call and team structures that provides support and continuity of care.
• Adequate critical care facilities.
• Access to skilled interventional radiology including out of hours.

[10] http://www.kingsfund.org.uk/publications/reconfiguration-clinical-services/summary/acute-surgical
11 Urbach DR, Baxter NN (2004). 'Does it matter what a hospital is "high volume" for? Specificity of hospital volume–outcome associations for surgical procedures: analysis of administrative data'. Quality & Safety in Health Care, vol 13, no 5, pp 379–83
[12] Naylor R, Wyatt M, Mitchell D. High volume surgery outcomes suggest there is safety in numbers. Health Service Journal;8 March 2012.
[13] https://www.theguardian.com/society/2012/jul/24/terence-stephenson-doctors-nhs
[14] Royal College of Surgeons (2013) '*Reshaping surgical services: principles for change'*

In Tayside, whilst these key resources are available, the current distribution means that for some patients their journey-of-care and time to access treatments varies. Unfortunately, in many cases the individual patient's needs for care can only be known following inpatient assessment and therefore some of the sickest patients will be subject to a delay in the time to begin their definitive treatment. Perth Royal Infirmary (PRI) model cannot offer the full range of specialties and treatment options that are available in Ninewells (NWH) (e.g. patients referred with abdominal or back pain being found to have a ruptured aortic aneurysm, patients whose best management would require Interventional Radiology) which means that Perth and Kinross residents already travel to NWH.

Workforce

A more compelling and linked driver for reconfiguration of services in many health boards is their capacity to provide appropriate medical cover 24/7 ([15]King's Fund, Briefing 2011).

The [16]RCS report from 2011 states:

'The reduction in working hours for trainees has led to a decrease in their level of experience and this now impacts critically on consultant workload and service provision. It is vital that providers, planners and commissioners recognise that these changes require more senior (consultant) input early in the patient pathway in order to maximise patient outcome.'

An analysis of the NHS Tayside senior medical workforce (consultant grade) in surgical services shows that many will reach retirement age in the next 5 years which at a time when the recruitment climate is difficult will present additional workforce challenges.

Studies have shown that the intervention of senior decision makers early in the patient's pathway improves outcomes for patients and makes more efficient use of resources[17,18]. A lack of early consultant involvement in the assessment of unscheduled surgical patients leads to poor outcomes[19,20].

Increasing pressure of unscheduled workload on surgeons within NWH, combined with the need to improve times to theatre for the patients with the highest bands of severity score identified by recent work with IHO, requires a re-design of theatres and clinical workforce. The work by IHO demonstrates the requirement for an increase in the number of theatres (up to a total of 3) to facilitate the faster treatment of very sick patients and to reduce the case backlog stretching into the evening and night. In turn this would require 2 consultants working together, assessing and treating unscheduled patients referred into the hospital and from other in patient services (e.g. paediatrics). This would ensure rapid discharge of those patients who do not require an inpatient admission or who do not require surgery and also support those recovering from surgery.

We must acknowledge that appropriately supervised doctors in training remain a valued and integral part of our sustainable workforce and their needs have to be addressed. An important facet for doctors in training within Tayside is the opportunities they have for education and learning, which must run in parallel with service provision. The [21]General Medical Council regulates all stages of medical training and professional development, both undergraduate and postgraduate. An annual training survey by the regulator assesses the

---

[15] www.**kingsfund**.org.uk/.../**briefing**-on-reconfiguring-**hospital**-services- candace-imison-**kings**-**fund**-september-**2011**.pdf

[16] Royal College of Surgeons of England (RCS), February 2011, and *'Issues in Professional Practice: Emergency General Surgery*'

17 Anderson I, Krysztopik R, Cripps N. *Emergency General Surgery Survey*. London:ASGBI;2010.

18 McNeill G, Brahmbhatt DH, Prevost AT, Trepte NJ. What is the effect of a consultant presence in an acute medical unit? *Clin Med* 2009; 9: 214–218.

[19] Wilkinson K, Martin IC, Gough MJ, Stewart JAD, Lucas SB, Freeth H, Bull B, Mason M (2010). An age old problem: a review of the care received by elderly patients undergoing surgery. London: National Confidential Enquiry into Patient Outcome and Death

[20] Martin S, Purkayastha S, Massey R, Paraskava P, Tekkis P, Kneebone R, Darzi A (2007). 'The surgical care practitioner: a feasible alternative. Results of a prospective 4-year audit at St. Mary's Hospital Trust, London'. Annals of the Royal College of Surgeons of England, 2007, vol 89, pp 30–35).

[21] http://www.gmc-uk.org/education/undergraduate/undergraduate_policy.asp

quality of training programmes to ensure a safe learning environment for patients and trainee staff. Currently NHS Tayside is at risk of failing to meet the required standards. This issue was central to the withdrawal of the surgical middle grade support of unscheduled care at nights and at weekends from PRI. Despite this the model across Tayside remains fragile. Business continuity plans are being invoked more frequently in order to divert unscheduled surgical care from PRI to Ninewells in the out-of-hours period.

Furthermore the continued use of locum doctors and agency nursing staff to manage workforce gaps places pressure on our commitment to deliver safe care and financial balance. The current configuration of services results in duplication at consultant level, vulnerable middle grade staffing rotas which require the use of locum agencies to support them, often at short notice, or which lead to rota breaches resulting in significant unbudgeted expenses.

Access

A number of studies suggest that greater distance to hospital is associated with an increased risk of mortality once illness severity has been taken into account. [22]Nicholl et al (2007) found a 1% increase in mortality risk for each 10km increase in distance (across a wide range of conditions, surgical and non-surgical).

However, it is critical to note that the timing of the start of appropriate treatment, rather than the timing of arrival at hospital that affects the outcome, so interventions by paramedics, rapid assessment and/or rapid access to the appropriate specialist team once at the hospital offsets or overcomes the risk created by the additional travel time ([23]Spurgeon, 2010). This is important and is a major factor as the current configuration of unscheduled service within PRI does not have an Acute Surgical Receiving Unit to streamline assessment and has limited access to CEPOD theatres thereby creating system related delays for patient access to theatres. Therefore the concern is that although a patient may get to hospital quicker, their time to definitive care is slower than an optimised configuration could achieve.

Cost

The [24]King's Fund report '*Reconfiguring hospital services:* Lessons from South East London*',* published in 2011 by Keith Palmer (a past Vice Chairman of NM Rothschild Investment Bank) suggested that hospitals should:

'*…focus on achieving best practice outcomes and patient experience … lower growth of hospital activity will result in excess capacity and stranded costs. Without reconfiguration, some financially challenged trusts will suffer a downward spiral of increasing deficits, declining quality of care and a further widening of the existing quality gap between the best and worst performers'.* He summarised stating *'reconfiguration of services across hospital sites is likely to be the only way that some (Heath Boards) can achieve financial balance'.*

Cost is an ever-present issue. Previous Board papers have highlighted that NHS Tayside has an operating service model that extends beyond its budgeted financial allocation in terms of site configuration, workforce, medicines, and operational costs. The SSS Outline Business Case aims to support a move towards high quality cost efficient services that allow resources to be mapped to need, effective use of our workforce assets and sustainable configuration of services to meet future demand.

[22] Nicholl J, West J, Goodacre S, Turner J (2007). 'The relationship between distance to hospital and patient mortality in emergencies'. *Emergency Medicine Journal*, vol 24, pp 665–68.

[23] Royal college of Surgeons *(2007),Separating emergency and elective care: Recommendations in practice'*

[24] www.**kingsfund**.org.uk/.../**briefing**-on-reconfiguring-**hospital**-services- candace-imison-**kings**-**fund**-september-**2011**.pdf.

Separating Unscheduled and Elective Surgical Care

Elective Care was identified as a key area of concern by the National Framework Advisory Group ([25]Scottish Executive, 2004). Although the work focused on orthopaedics there are parallels with all elective surgery. Concerns include how to best streamline the hospital component of elective care, while ensuring good practice in assessing need and capacity planning. It is also important to understand the implications for the whole service if there is separation of unscheduled and elective care. The report strongly recommended the separation of unscheduled and elective flows and went further to recommend that NHS Scotland develops centres / facilities that deal only with elective care either on existing hospital sites or in new buildings.

A report by the [26]RCS, '*Separating emergency and elective care: Recommendations in practice' (2007)* echoed the same principle. More specifically it recommended a physical separation of (unscheduled and elective) services and facilities. The report went to say:

- The separation of unscheduled and elective surgical care can facilitate protected and concentrated training for surgeons in training.
- Separating unscheduled and elective services can prevent the admission of unscheduled patients (both medical and surgical) from disrupting planned activity and vice versa, thus minimising patient inconvenience and maximising productivity for the Trust.

This view was reinforced by the RCS in written evidence to the Health Select Committee of the Westminster Parliament[27], (September 2013) who said:

'The College believes that, when carefully planned and adequately resourced, the separation of unplanned emergency and planned elective services will improve the quality and safety of care delivered to patients.'

In line with the above, on the PRI site there is daily variability in the delivery of elective care driven by the pressure to manage unscheduled and elective cases within the same flows. As the current operating model involves the provision of unscheduled care on two hospital sites this daily variability is also evident on the NWH site whereby unscheduled care will always take priority over elective surgical admissions. This has serious implications for the patient experience leading to short notice cancellation of elective surgery as, other than Stracathro Hospital, which has strict elective admission criteria there is no other [28]ring fenced elective facility.

Institute of Healthcare Optimisation[29] (IHO)

NHS Tayside is in the first tranche of Scottish Boards working with IHO. There are 2 IHO projects; to improve theatre access for unscheduled surgical patients (IHO 1) and the second (IHO 2) is to optimise the process of admission for elective care

IHO 1

A classification system has been developed to ensure that unscheduled care patients access theatre within clinically accepted wait times for their condition. This classification is in effect a standardised severity score of unscheduled surgical care.

---

[25] Scottish Executive (2005). A National Framework for Service Change in the NHS in Scotland. BUILDING A HEALTH SERVICE FIT FOR THE FUTURE.

[26] Royal college of Surgeons *(2007),Separating emergency and elective care: Recommendations in practice'*
[27] http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/171vw09.htm
[28] Ring-fenced: protected beds which only able to be used for a particular purpose such as elective care with no incursion from unscheduled surgical or medical cases.
[29] www.ih**optimize**.org

The top 3 most urgent categories, which define the maximum time to theatre following the decision to operate, for best outcomes for a particular patient, are A - <45 min; B - < 2 hrs; C - < 4 hrs. The compliance rate for these grades within core working hours (09.00 – 16:30) was 60%, 63% and 73% respectively. Out of core working hours the compliance rates changed to 50%, 84%, and 87% respectively. The IHO study also reported that failure of compliance across all categories resulted in an increase in length of stay of 1.6 days. This in turn equates to a loss of 443 bed days / year. The report did not take into account delays in performing surgical assessments and booking theatres.

In order that NHS Tayside can create a system to reliably deliver the performance required for unscheduled theatre access a redesign of current CEPOD configuration is essential. Throughout this case unscheduled theatres will be referred to as 'CEPOD' after the [30]Confidential Enquiry into Peri Operative Deaths Report, 2006. The theatre modelling scenarios presented by IHO required an increase in CEPOD availability of 2-3 theatres in NWH. This will require to be balanced with the impact of the effect on elective care. Following discussion with clinical staff it would seem appropriate to increase the number of consultants providing unscheduled surgical care on the NWH site within peak times. This would enable parallel assessment and operating by senior clinicians. In tandem with the availability of more than 1 CEPOD theatre it would be expected to expedite high severity score patients and reduce overspill beyond of core hours working time.

IHO 2

The main finding of IHO regarding PRI was that it is underutilised compared to NWH and by increasing elective utilisation there was the potential to significantly increase elective case volume at PRI. In addition to improving actual theatre utilisation this would require '[31]smoothing' of elective admissions, spreading admissions more appropriately across the week, so reducing the likelihood of cancellations and the number of beds required to deliver elective surgical care. This in turn is best delivered in a system with greater separation of elective and unscheduled care.

Therefore the recent IHO work has also identified the need for improvements in the elective surgical care service within Tayside. These in turn need to be considered in the wider context of potential unscheduled care reconfiguration.

Local Background

Sustainability, Resilience and Certainty

There are a number of issues old and new affecting the provision of Surgical Services in Tayside.

- The time to unscheduled surgery in the sickest patients.
    - Between 30-40% of such patients did not achieve this clinically agreed time to theatre.
    - This results in patients being sicker at the point of definitive treatment with consequent longer recovery times and higher risk of complications and even death.
    - In NWH the unscheduled demand can be greater than the ability of one unscheduled (CEPOD) operating theatre and one surgeon to deliver.
    - In PRI there is limited access to a CEPOD theatre as it is shared with Orthopaedics. This can result in either delay to surgery or interference with access of elective cases to theatre.

[30] http://www.ncepod.org.uk

[31] In complex service systems, quality and efficiency depend on the ability to consistently align resources with demand. In healthcare, where patient flow can be unpredictable, the only way to overcome this operational challenge is through effective management of variability in patient demand for services. IHO's Variability Methodology® techniques allow hospitals to eliminate unnecessary peaks and valleys in patient flow.

- The effect of unscheduled care on elective care delivery.
    - This leads to both short notice cancellations of elective admissions and day-of-surgery cancellations.
    - Patients who have taken time off work, organised care for those at home and come to terms with the need for and worries of submitting themselves to surgery are disappointed and inconvenienced.
    - Plans by patient, relatives, clinicians and hospital can be severely disrupted

- The resilience of staffing and resource levels to deliver unscheduled surgical care.
    - As mentioned above, there are on occasions overwhelming demands on unscheduled care in NWH. This is both in terms of pressure on staff and on theatres. It should be noted that currently about 420 Perth and Kinross patients receive their unscheduled surgical care in NWH.
    - In NWH there is a pressing need to increase both staffing and theatres dedicated to unscheduled care.
    - In PRI a consultant and a junior trainee provide the overnight weekday service; there is no flexibility or resilience. A single absence can cause closure of the PRI service and transfer of unscheduled care to NWH.
    - Tayside currently operates 2 parallel rotas for surgical consultants delivering unscheduled care with CEPOD theatres on two sites.

- Uncertainty in unscheduled care due to the distribution of specialty services within Tayside.
    - Currently a number of unscheduled care needs are focused on NWH (e.g. Vascular, Major Trauma and Interventional Radiology).
    - Patients from Perth and Kinross who are known to need these before or following admission are transferred either directly or indirectly to NWH.
    - It is not possible to provide these services on 2 sites within Tayside (and in the case of Vascular and Interventional Radiology, within Tayside and Fife).
    - Any patient who requires transfer from PRI will have an inbuilt delay to definitive treatment.

To achieve sustainability, resilience and certainty an option appraisal was carried out to ascertain whether there was a way of not only addressing some or all of these issues but also to improve the quality and safety of care delivered to all patients (elective and unscheduled), across Tayside.

Options

Following consultation with staff and public partners a list of options was reduced to 2 for more detailed exploration and evaluation. The *status quo* was deemed unacceptable.

Current Service Provision (the status quo)

NHS Tayside provides healthcare to around 500,000 people covering four Local Authority areas; Angus, Dundee, Perth & Kinross and North East Fife. Between October 2014 and September 2015, there was a total of 12341 surgical admissions (General Surgery, Vascular Surgery and Urology) - 8546 unscheduled and 3795 elective surgical admissions to NHS Tayside. As highlighted in local demographic changes, the population covered by NHS Tayside is set to increase; therefore capacity will also need to increase otherwise the demand for some types of surgical services will outstrip the ability of the service to cope.

Unscheduled Surgical care is currently delivered on two sites; Ninewells Hospital (NWH) and Perth Royal Infirmary (PRI). Based on 2014 data 80% of unscheduled surgical admissions were to NWH and 20% to PRI (total 8546).

NWH receives unscheduled admissions on a 24-hour, 365-day basis. There is on-site access to a broad range of specialist and subspecialist teams and services; Upper Gastrointestinal, Hepato-Billiary, Lower Gastrointestinal, Vascular, Urology, Gynaecology and Interventional Radiology. There are a number of consultant led teams in Anaesthesia separately covering operating theatre related care and Critical Care. There is an Acute Surgical Receiving Unit separate from elective services and a dedicated manned 24-hour theatre, acronymically named CEPOD ([32]Confidential Enquiry into Perioperative Deaths). Ninewells has significant volumes of out-of-hours unscheduled cases making up to 30% of case hours in the hospital.

Conversely, unscheduled surgical care for General Surgery and non-life threatening Urology[33], is only available in PRI Monday 08.00 - Friday 17.00. Patients admitted out of hours during the week that do not require immediate intervention may displace elective patients on elective lists the following morning. If surgery can wait until the afternoon they can be placed on a dedicated general surgical CEPOD list from 13.00 – 16:30. Patients, who require major surgery overnight, occasionally require transfer to NWH after stabilisation. This is mainly due to the lack of a full surgical team to provide theatre and postoperative care. On weekdays out-of-hours general surgical patients share a single CEPOD theatre with orthopaedics. The out-of-hours nursing theatre team is non-resident and called in from home if required. As there is no Acute Surgical Receiving Unit, unscheduled surgical service on the PRI site is delivered from the 30 bed surgical ward, shared with the elective surgical activity.

In PRI due to the inpatient absence of certain key specialties and services patients requiring the input of Vascular Surgery, Urology, Paediatric Surgery, Gynaecology, Interventional Radiology, or following Major Trauma, are either transferred to NWH or are referred/taken directly to NWH. There is one Consultant General Surgeon and one Consultant Anaesthetist available in PRI. The latter has responsibility for both theatre work and critical care.

Some of the issues related to bed availability that affect PRI and NWH are more acutely felt in the former due to its smaller size and centre on delayed discharge. There is a joint Health and Social Care capacity and flow programme underway to help address this issue.

[32] CEPOD 2004, http://www.ncepod.org.uk/classification.html

[33] Concerns have been raised with respect to the urology admissions as not all the general surgeons have training or experience in the specialty.

Option 1

Perth Royal Infirmary (PRI) • There will be no unscheduled admissions for surgery • Expanded and central role in elective care delivery for Tayside. • Enhancement of critical care through re-engineering of High Dependency / Post-operative Care Unit • Overnight cover for inpatient unscheduled care arranged by the Tayside surgical team
Ninewells Hospital (NWH) • All unscheduled admissions in Tayside will come to NWH 24/7. • Significant shift of elective surgery from NWH to PRI.
Stracathro (SRTC) • Further development of day case and minor elective surgery. Patients who fulfil the anaesthetic and surgical criteria will increasingly have their care delivered at SRTC.

What does this mean?

- If you need unscheduled surgery you will go to NWH and will remain there till the end of the inpatient stay no matter where in Tayside you live (approximately 1700 patients who would currently be admitted to PRI being seen in NWH giving a total of approximately 7700+ unscheduled admissions (based on 2014 figures).
- There will be no facility for unscheduled surgical admissions in PRI.
- You may have major elective surgery at PRI or NWH. Fewer elective cases from Perth will travel to NWH and more patients from out with Perth will travel to PRI (an anticipated additional 600+ patients (depending on case-mix) added to the 1008 patients already receiving elective general surgical care).
- If you are fit and meet the criteria you are likely to have minor elective procedures at SRTC in line with an accredited list.
- There will be an enhancement of critical and post-operative care in PRI to deal with an increase in major elective surgery.

Strengths

- This fits all the criteria for unscheduled surgical care outlined by the Royal College of Surgeons and the Association of Surgeons of Great Britain & Ireland.
- With the transfer of unscheduled care from PRI to NWH there will be an expansion / enhancement of unscheduled care within NWH. In line with IHO modelling there will be an opportunity to increase the consultant numbers and CEPOD theatres available for unscheduled surgical care. This will be due to centralising of this service on a single site, removing duplication with a consequent improvement in the standard and speed of care.

- There will be no urgent transfers of unscheduled care patients from PRI due to staffing issues overnight and no variability in delivery and care.
- No mixing of unscheduled and elective care streams in PRI reducing cancellations.
- There would also be an anticipated increase in theatre utilisation over the current level due to the separation of unscheduled and elective care. This separation would also facilitate the use of 'admission smoothing' modelled by IHO further improving the number of patients treated in PRI.
- Repatriation of some Perth elective patients from NWH to PRI with an increase elective capacity (total 1600+ depending on case-mix).
- The services anticipated to be involved in the elective care would be in part aimed at repatriating many Perth and Kinross patients.

Weakness

- Patients and relatives have to travel to NWH for unscheduled care.
- There will be rare cases of post-operative elective cases requiring a return to theatre being transferred from PRI to NWH.

Option 2

Perth Royal Infirmary (PRI) • All unscheduled general surgical and (urological*) admissions for Perth and Kinross will be delivered in PRI 24/7. • A significant part of elective surgical cases from Perth and Kinross will need to be transferred to NWH and SRTC. *further discussion required
Ninewells (NWH) • Fewer unscheduled admissions will be seen in NWH 24/7. • More elective surgery would have to be provided in NWH.
Stracathro (SRTC) • Further development of day case and minor elective surgery. Patients who fulfil the anaesthetic and surgical criteria will increasingly have their care delivered at SRTC.

What does this mean?

- If you need unscheduled General Surgery and are resident in Perth and Kinross you will go to PRI, non-Perth and Kinross residents will go to NWH (an addition of approximately 500+ more patients Perth and Kinross unscheduled general surgical patients were seen in NWH in 2014).
- If you need unscheduled Vascular, Paediatric, major Urological, Gynaecological Surgery or Interventional Radiology you will go to NWH either directly or be transferred from PRI.
- Nearly all elective care is likely to be at NWH or SRTC.
- If you are fit and meet the criteria you may have minor elective procedures at

SRTC in line with an accredited list.

Strengths

- An increased number of unscheduled care General Surgical patients will be treated in PRI.
- There will be less travelling for relatives of these patients.

Weakness

- A proportion of patients and relatives will still have to travel to NWH for unscheduled care (e.g. those requiring Vascular Surgery or Interventional Radiology as these cannot be delivered across 2 sites).
- Due to increased unscheduled activity there will be a reduction in elective theatre time and elective beds leading to significant displacement of elective activity away from PRI. Day-case surgery will remain in PRI.
- There will need to be an expansion in the CEPOD theatre provision in PRI. This will reverse the current general surgical theatre provision of 1 CEPOD session[34] (pm only) and 2 elective (1 all-day list). This leaves only 1 half day list per day which is insufficient for significant major surgery.
- There is concern regarding use of the remaining elective theatre sessions as the associated beds for elective care may be occupied by an increased number of longer stay patients to the point of there being potentially no elective care beds and thus an inability to use the remaining general surgical theatre.
- There would remain a significant degree of unpredictability in the delivery of and remaining elective surgery and to a lesser degree in unscheduled delivery.
- Workforce planning:
    I. There will need to be a full middle grade staff rota to support unscheduled activity. This is undeliverable without significantly increasing the middle grade staff numbers. There is concern that the increase in activity will be insufficient to satisfy training demands. Recruitment of middle grade level hospital posts is difficult.
    II. Introduction of additional Advanced Nurse Practitioners and non-medical Prescriber in PRI
    III. Increase in discharge assessment support (physiotherapists, occupational therapists
- The transfer of elective cases from PRI to NWH would be anticipated to increase the waiting times for surgery across the health board.
- Increase in theatre nurses for evening work in PRI.
- Service developments modelled by IHO related to CEPOD theatres and elective admission smoothing will be significantly restricted.
- Operating costs will be greater.

Preferred Option

As discussed previously, in any reconfiguration of hospital services there are four interlinked drivers: *quality and safety*, *workforce*, *access* and *cost*. The strengths and weaknesses of

[34] 1 session = 4 hours (half a day)

the status quo with Option 1 and Option 2 can be mapped and summarised against these drivers.

Status quo

Quality	Variable quality between sites relating to access to CEPOD theatre, dedicated Acute Surgical Receiving Service, the lack of full range of services and specialties on PRI site. In addition, unpredictable times to definitive treatment due to need for continuing inter-hospital transfers from PRI to NWH. Patients requiring access to elective service will continue to be at risk of cancelled surgery.
Workforce	Vulnerable middle grade staffing rota resulting in the use of locums and roster breaches.
Access	Variable between times and patients due to different provision for assessment, diagnostics and theatres. Variable between sites due to different levels of access to major subspecialties times. Likely delays and patients' needs not met in timely manner.
Costs	Unpredictable additional costs associated with use of locums. Inefficiencies due to PRI CEPOD theatre utilisation, on-call teams required for low volume demand and lack of dedicated, ring fenced facility for major surgery. Increase in underutilisation compared to NWH.

Prolongation with the status quo means that there would continue to be variability in the nature, scope, site and provision of services in Tayside. The developments needed following the IHO study would be significantly more difficult to deliver, more robust sustainable models of manpower rostering would be hampered and the problem of mixing elective and unscheduled care would continue.

Option 1

Quality	Meets standards for safe, high quality unscheduled care, dedicated ASRU, 24/7 CEPOD and ring fenced elective facility for Major Surgery at PRI. Opportunity for further efficiency gains in theatre utilisation, reducing unscheduled length of stay.
Workforce	Most stable configuration due to the amalgamation of rosters, releases resource associated with running multiple on-call teams / allows team amalgamation to enable service improvement.
Access	Perth & Kinross residents will travel more for unscheduled care but less for elective care.
Cost	Anticipated reduced operating costs as mitigates locum usage, nurse agency requirement for mobile theatres and local outsourcing of elective activity

This provides equitable access for patients to a specialist, dedicated acute surgical receiving unit (ASRU) for all patients in Tayside requiring an unscheduled admission to hospital. The increase in demand can be accommodated within the current ASRU and unscheduled theatre footprint on the NWH site due to the low volume unscheduled demand within PRI.

This creates significant release of under-utilised capacity on the PRI site as the current model provides 5 half day sessions of CEPOD theatre per week, with low demand and utilisation of this theatre resource.

Low occupancy rates are necessary within the theatre as it is critical to ensure patients can access theatre when this is needed for clinical priority.

This option has the opportunity to increase elective surgical cases at PRI by 600+ per annum.

This provides a safe, high quality unscheduled surgical care service both in and out of hours. Cost efficiencies in this model could be created by releasing temporary theatre capacity

Option 2

Quality	Less variability in terms of access to CEPOD times. Still issues with access to multiple specialities and technologies. Potential problems due to continued mixing of elective and unscheduled care
Workforce	Requires significantly increased staffing across a number of disciplines. In turn this may equate to further concerns over rota stability.
Access	Perth & Kinross residents requiring unscheduled General Surgical care will have more access to PRI due to implementation of 24/7 receiving in PRI. This will still require travel to NWH for other speciality care and interventional radiology. Due to the displacement a large number of elective cases more \Perth & Kinross patients will need to travel Dundee or Angus than currently do so.
Costs	Significant increase in workforce budget. Capital resource required to introduce capacity on site for elective, unscheduled, interventional radiology services. This option has the potential for not being able to fully use all operating theatres in PRI unless an additional ward provided for elective activity.

This option cannot be delivered in totality without significant investment in infrastructure on the PRI site including an additional surgical ward, introduction of 24/7 interventional radiology and a dedicated CEPOD theatre. We will still not be able to provide interventional radiology at PRI due to the limited specialist skills available and the associated speciality technology/equipment. Patients requiring vascular care, renal support or other subspecialist collaborations in care will still need to come to Ninewells.

There would require to be investment in a Consultant delivered service as there are insufficient trainees to support 2 full out-of-hours rotas for acute surgical receiving whilst retaining an effective learning experience and supervision.

Conclusion

In acknowledgment of the above balance of benefits and costs the recommended option of the surgical and management team is option 1.

Both options provide an opportunity to change the way services are delivered across NHS Tayside. Importantly both options require NHS Tayside to ensure utilisation of all three sites. However it is important to note that only option one will maintain and strengthen the surgical service at PRI by increasing major general surgery, utilising the inpatient bed and theatre capacity, freed up by having a single site ASRU. Furthermore option 1 strengthens the surgical model for the delivery of unscheduled and elective care across NHS Tayside.

This paper recommends the configuration of Surgical Services as outlined in option 1 and that progress towards a three-month public consultation is commenced with immediate effect.

Part One

Strategic Case for Change

1.1 Introduction

This outline business case (OBC) summarises the current delivery of surgical care related to the provision of all General Surgery (including Upper Gastrointestinal, Lower Gastrointestinal, Hepato-Billiary, Vascular Surgery and Urology) within NHS Tayside. The case covers relevant National Guidelines and Standards and brings together the recent work undertaken within NHS Tayside under the auspices of Shaping Surgical Services (SSS) and the Institute of Healthcare Optimization (IHO).

One of NHS Tayside's key objectives is to be an organisation which continually strives to improve patient experience and outcomes. This OBC sets out the case for changes in surgical services necessary to meet the 2020 Vision for Health and Social Care in NHS Tayside and the NHS Tayside 5 year Transformation Programme. It summarises some of the challenges faced by NHS Tayside over the next few years with the increase in demands for health and social care and changes in NHS workforce. It is our job to ensure that we can continue to provide the high quality health and care services the people of NHS Tayside expect and deserve into the future, securing the best possible outcomes for people from the care and support they receive whilst responding to the most immediate and significant challenges we face. It is important to emphasise our continued commitment to pursuing the three Quality Ambitions of safe, effective and person-centred care, as set out in the [35]Quality Strategy (2010) and this work represents the commitment of the clinicians and management to ensure surgical services are safe, effective and sustainable for future population and patient needs.

This OBC highlights concerns regarding the current configuration of services and sets out two strategic visions (referred to in this case as Option one and Option two) for the reconfiguration a core clinical service.

This OBC has been developed in accordance with the fundamental approach outlined in HM Treasury guidance – [36]*The Green Book.* The case also takes note of the Scottish Health Council's guidance and Scottish Government CEL (4) 2010[37] ("*Involving Patients, Carers and the Public in Option Appraisal for Major Health Service Changes*") and to the Scottish Capital Investment Manual for NHS Scotland, issued under the terms of CEL(19) 2009. [38]

The business case is intended to guide NHS Tayside Board to undertake decision regarding the shape of surgical services for NHS Tayside by endorsing the recommended a preferred option for service delivery. The evidence presented in this case is based on a clinical case for change bridging quality and safety and the economic case to identify the most sustainable and affordable option. This case must also consider the impact of the recommended option to development of service to meet population needs in particular

[35] http://www.gov.scot/Publications/2010/05/10102307/0

[36] The Green Book - Appraisal and Evaluation in Central Government, HM Treasury – available at http://www.hm treasury.gov.uk/data_greenbook_index.htm.

[37] Informing, Engaging and Consulting People in Developing Health and Community Care Services. CEL 4 (2010), Scottish Government http://www.sehd.scot.nhs.uk/mels/CEL2010_04.pdf.

[38] http://www.scim.scot.nhs.uk/PDFs/Manuals/BC/BC_Guide_1.pdf Option Appraisal Guide: A Practical Guide to the Appraisal, Evaluation, Approval and Management of Policies, Programmes and Projects – available at http://www.scim.scot.nhs.uk/Support/OA_Guide.htm

informing potentially affected people, staff and communities and involving them in a (proportionate) consultation on the agreed options. This OBC is subject to an equality and diversity impact assessment ensuring that any potentially adverse impacts of the recommended service change have been taken account of.

1.2 Background

Shaping Surgical Services (SSS) programme of redesign was established in 2014 with the aim of undertaking a comprehensive whole system review across the Tayside General Surgery Service to ensure the provision of a sustainable high quality, person centred, safe, effective and affordable surgical service. The context for the service redesign is based on a number of key issues associated with the current operating model.

SSS is a clinically led, managerially facilitated programme of redesign to enable NHS Tayside to meet the changing needs of the population and deliver sustainable services to ensure the right care is delivered at the right time in the right place at the best possible cost for the benefit of patients requiring surgical treatment & care.

The aim of SSS is to:

- Maximise the **patient experience** for both elective and unscheduled surgical pathways,
- Improve **effectiveness** and service quality to meet changes in population demographics and the care needs of people,
- Improve **efficiencies** in the throughput of services so that patients receive treatment at the right time with the right resources and that care is safe,
- Meet the **statutory requirements** regarding workforce compliance and the changing workforce demographic,
- Meet the **statutory requirements** regarding waiting time treatment guarantee (TTG) for elective general surgery and cancer care,
- Provide **economies** in the provision of the existing service to deliver affordable care that is sustainable.

1.3 Strategic Context

SSS is a component part of NHS Tayside's broader clinical strategy and Transformation Programme to develop future models of delivering health and healthcare to meet the needs of the population in challenging financial times. The first strand focuses on the scope and nature of surgical care related to clinical safety and effectiveness. The second strand focuses on the necessity to deliver a number of systemic changes that are necessary as part of NHS Tayside 5 year Transformation Programme proposals to effectively utilise workforce, financial and capital assets ensuring everything we do delivers value for patients and the public. Both strands need to deliver in unison in order to succeed and this case underpins how NHS Tayside can achieve that.

The SSS strategic programme of redesign is an important contributor to the National Clinical Strategy[39] (2015), in particular ensuring that patient safety, clinical effectiveness, quality and value underpin all service planning decisions. Maintaining and improving safe, sustainable and high quality surgical care is the primary goal driving the SSS work programme. A proposed reconfiguration of hospital services is outlined in this case with a particular focus on the system related changes to ensure safe and effective unscheduled surgical care. Safe,

[39] Realistic Medicine. Chief Medical Officer's Annual Report 2015/16. Http://www.gov.scot/Resource/0049/00492520.pdf

effective and efficient delivery of unscheduled surgical care depends on a number of key elements (clinical assessment, radiology, theatres, and critical care). This requires teams of experienced clinical staff (Medical, Nursing and Allied Health Professionals) working together to provide the best outcomes for patients.

Patients requiring unscheduled surgical care are amongst the sickest patients treated in hospitals. The National Audit Office for England and Wales reported that unscheduled admissions across all specialities have increased by 47% over the last 15 years[40]. Given that unscheduled anaesthesia and surgery make up an estimated 40–50 per cent of the surgical workload in the UK ([41]Royal College of Anaesthetists, 2014), there has been a steady build-up of pressure on the delivery of unscheduled care for surgical patients.

Poorly delivered unscheduled surgical services have a number of consequences. They increase costs to the NHS as a consequence of complications, returns to theatre and increased length of stay. There is also a consequence to society more generally through increased rehabilitation costs and welfare support. Most importantly there are personal costs to patients and their families through poor quality of life, morbidity and mortality. Delays in treating unscheduled surgical patients can also result in additional complications and higher mortality. It must be recognised that rapid access to imaging and access to a fully staffed and resourced theatre for those patients requiring immediate intervention, will not only be safer for patients but will be cost effective in the longer term and is the aim of the options outlined in this case.

NHS Tayside has been at the forefront of driving safer care and patient safety to ensure best outcomes for patients and use of available resources as effectively as possible. However there is still more we can do so that we can ensure that patients stay in hospital only as long as necessary and are supported appropriately when they return to their communities by responsive health and social care services.

The NHSScotland National Clinical Strategy[42] (2015) supports the evidence that some complex and many less complex operations are best performed in more specialist settings by separating flows of patients. The evidence proposes that teams who are more specialised in doing complex operations frequently get better outcomes for patients, tend to have fewer side effects, and typically spend less time in hospital. This evidence underpins the necessary systemic changes required for surgical services in NHS Tayside, acknowledging that services should be planned at a national, regional and local level on a population rather than geographical boundary basis. This will mean that, for some services, there could be more specialist inpatient units /services where evidence supports interventions concentrated in such a way to deliver first class outcomes. Primarily though, the aim is to ensure that services are provided as locally as possible where clinically appropriate.

SSS forms a key part of NHS Tayside's Local Delivery Plan objectives, specifically to deliver the 12 week Treatment Time Guarantee (TTG) as set out in legislation through "The Patient Right's (Scotland) Act"[43] (2011) and ensure surgical services are designed to ensure that cancer care pathways support early diagnosis, timely treatment to achieve better survival outcomes. NHS Tayside is required to consistently deliver the performance mandated by the legislation however current performance is challenging and needs to be addressed to ensure the delivery of these guarantees. This will be discussed in later chapters.

[40] Emergency admissions to hospital: managing the demand, National Audit Office, 2013.
[41] Royal College of Anaesthetists (2014). *Guidelines for the provision of anaesthetic services*.
London: Royal College of Anaesthetists. Available at: www.rcoa.ac.uk/system/files/GPAS-2014-FULL_0.pdf
[42] Realistic Medicine. Chief Medical Officer's Annual Report 2015/16. Http://www.gov.scot/Resource/0049/00492520.pdf.
[43] http://www.legislation.gov.uk/asp/2011/5/pdfs/asp_20110005_en.pdf

1.4 Vision

NHS Tayside's vision is that by 2020 we will create a surgical service that contributes to our ability to respond to the changing population demographics and to deliver high quality, high value care, balancing capacity with demand, optimising all of our assets. The optimisation and reconfiguration of surgical service is also an essential element in building service resilience in response to population demographics and in supporting the National Clinical Strategy to develop an Elective Treatment Centre locally.

In 2014 the Chief Medical Officer of NHS Scotland produced the annual report entitled "[44]Realistic Medicine" which challenges all NHS Boards to deliver services and patient care that reduces unwarranted variation in clinical practice to achieve optimal outcomes for patients. This OBC highlights the current variation that exists between hospital sites and how this can be reduced for the benefit of patients.

Important to the delivery of sustainable services is ensuring a highly skilled workforce and a strong approach to workforce planning, recruitment and retention of staff. The recommended option will enable NHS Tayside to respond to the current workforce challenges and to deliver sustainable services into the longer term for the benefit of the population.

1.5 Scope

The scope of Shaping Surgical Services comprises of General Surgery which includes colorectal, Hepato-Billiary and Upper Gastro Intestinal surgery, Urology, and Vascular Surgery specialities. More specifically the element of the patient pathway under consideration is the adult in-patient peri-operative phase of elective and unscheduled (emergency) surgery.

For clarity, elective surgery is surgery that is planned and elective in advance whereas emergency surgery is unscheduled with patients referred by their GP or through self presentation at A&E services or through 999 response services. The context of emergency surgery for the purpose of the document will be referred to as unscheduled, and in any wider public engagement. This is because emergency care encompasses a wide spectrum of cases and not all unscheduled care is a 'surgical emergency' ([45]Patton & Thakore, 2013).

Service provision within specialist surgical services and paediatric surgery are not in scope of this OBC nor is outpatient or diagnostic services. The scope relates to services across the 3 acute hospital sites in NHS Tayside: Perth Royal Infirmary (PRI), Ninewells (NWH) and Stracathro (SRTC).

1.6 NHS Tayside Catchment Area and Population

NHS Tayside provides healthcare to just under 500,000, people covering four Local Authority areas; Angus, Dundee, Perth & Kinross and North East Fife. Tayside covers 3000 square miles of Urban, Accessible Rural and Rural populations. According to the Scottish Index of Multiple Deprivation (SIMD) three of the four local authorities covered by the NHS Tayside have areas within the 15% most deprived populations in Scotland, with the majority of these areas being in Dundee City.

---

[44] www.gov.scot/Resource/0049/00492520.pdf

[45] Patton, G., & Thakore, S. (2013). *Reducing inappropriate emergency department attendances-a review of ambulance service attendances at a regional teaching hospital in Scotland*. *Emergency Medicine Journal*, *30*(6), 459-461. DOI: 10.1136/emermed-2012-201116

The largest age bands within Tayside's population are 50-54 year olds (7.5% of the population) and 20-24 year olds (7.2%). This is consistent with both the Scottish average and other Scottish Local Authority areas and has implications for projected demand for services going into the future.

Tayside's population is estimated to increase overall in the next 25 years with the greatest increase in Perth & Kinross by 24.2% by 2037, Angus shows a predicted decrease of 0.8% in growth which is not solely in the older population, Perth and Kinross under 16 populations are predicted to increase by 26%, and Dundee's by 25% during the same period.

Locally, Perth and Kinross is projected to see a 27% increase in new house building by 2037 and is set to be one of the fastest growing regions in Scotland. In the year to 31 March 2016 over 500 new houses were built which was an increase on the previous year and suggests house sale completions are beginning to return to pre-recession levels. [46]

These changes in population signify the need for changes in the way surgical services are delivered which are reflected in the proposals put forward in this case and are concurrent with the National plan for elective treatment centres. This will provide the resilience required for NHS Tayside to manage the growing demand for surgical services especially for elective surgery closer to patient home. This is important because some research has shown that over a person's lifetime they are more likely to have elective surgery with a predicted 5 operations per person over their lifetime ([47]Weiser et al, 2012). The elective treatment centre alone will be insufficient and there is an urgency to create an enhanced safe effective surgical unscheduled model of care.

1.7 Health Inequalities

Health inequalities are the differences found in health status and health outcomes between different groups, especially between those who are best off and those worst off in society. Health inequalities arise from variations in a range of factors which include access to health services, quality of health care and others external to the health service such as wealth, lifestyle, genetic and environmental factors.

Evidence suggests that many populations, particularly those in deprived areas have difficulty securing access to NHS services and also suffer multiple external disadvantages ([48]Appleby & Deeming 2001).NHS Tayside needs to understand these inequalities in detail to ensure any option selected through this OBC takes cognisance of the ease of access for socio-economically disadvantaged communities whilst balancing the clinical safety concerns. Numerically there are less people living in poverty in rural areas than in urban areas. However, the experience of poverty for those living in rural areas may be different and it is important that this is understood when changing service delivery. The infrequency and cost of public transport prevents people from accessing a range of services and support including NHS hospitals. These difficulties are exacerbated if the person is disabled and/or the person needs to be accompanied by a carer when

Within Tayside, it is estimated that the population will have increased by 11% in 2030. This is above the anticipated growth rate for Scotland as a whole. The highest growth area is Perth and Kinross, where it is expected to increase by 24.2%.

[46] *All statistics National Registrar of Scotland, (2015).*
[47]Weiser et al (2016)Size and distribution of the global volume of surgery in 2012 *Bulletin of the World Health Organization* 2016;94:201-20 http://dx.doi.org/10.2471/BLT.15.159293.
[48] Appleby J, Deeming C. (2001) Data briefing. Inverse Care Law. *HSJ* 111: 37

travelling [49](Scottish Government Social Research, 2009). Some of these challenges already exist in NHS Tayside where rural populations already travel great distances for care however we must asses any option for change to ensure the impact is considered.

Dundee is Scotland's fourth biggest city and the population for the year 2016 is 149,511. It has a wide ethnic population and has about 4,000 Asian inhabitants, which is the fourth biggest Asian community in Scotland. The non-white ethnic population in 2001 numbered 5,333 people in Dundee City, and the largest minority ethnic group was Pakistani (around 1,700 in 2001). In contrast, in the population of Angus the non-white ethnic population in 2001 numbered 854 people, the Chinese community was the largest minority ethnic group. The non-white ethnic population in 2001 numbered 1308 people in Perth and Kinross, the Chinese community formed the largest minority ethnic group and in 2006/07 showed the number of migrant workers in Perth and Kinross to be 1,940, an increase of 471% since 2002 ([50]National Register Scotland, 2016).

A national research report identifying service gaps for minority communities ([51]Mind the Gap, 2016) demonstrated that there have been significant changes in the needs and profile of Scotland's minority-ethnic communities; major themes include diversification across communities, increased ages of new migrants as well as recent changes in asylum seekers and refugees.

Ethnicity can impact upon engagement within a healthcare system, such as cultural differences and behavioural variations. The needs of these minority groups have to be considered in any option that is implemented with views being sought from minority communities, in particular Gypsy/Traveller communities and Polish communities. Gypsy Travellers numbers are estimated at less than 0.5% of the Scottish population however [52]Perth & Kinross Gypsy/Traveller Strategy 2013 – 2018 suggests that this population needs to be considered in any service change planning citing practical problems of access whilst travelling, mismatch of expectations between Travellers and health staff, and attitudinal barriers. The increase in migrant workers has also increased the resident population, highest in the Polish communities. The Polish community of Angus and Dundee is 1% of the population but rises to 2% in Perth & Kinross ([53]Scotland Census 2011). This represents approximately 4,000 - 6,000 population. This is significant when related to cultural issues in access to health care. In Poland it is easiest to go to accident and emergency and be seen by a specialist rather than go to a GP or local services.

[49] Scottish Government Social Research 2009The Experience of Rural Poverty in Scotland Qualitative Research with Organisations Working with People Experiencing Poverty in Rural Areas. http://www.gov.scot/Resource/Doc/262658/0078512.pdf
[50] Nation register Scotland 2016 http://www.nrscotland.gov.uk/
[51] https://www.pkavs.org.uk/media/uploads/Mind%20the%20Gap%20Report%20Jan%202016.pdf
[52] www.pkc.gov.uk/CHttpHandler.ashx?id=27645&p=0
[53] http://www.scotlandscensus.gov.uk/

Both of these communities as with other minority/ disadvantaged groups will need to be considered in options that change unscheduled or elective service access. This will be part of an engagement plan that is developed on the basis of an Equality and Diversity Impact Assessment.

Key Messages

- In Tayside it is estimated that the population will increase by 11% by 2023. The highest growth area is Perth& Kinross, which is expected to increase by 24.2%.
- Between October 2014 and September 2015, there were 4,127 elective surgical admissions and 8,549 unscheduled surgical admissions to NHS Tayside for general surgery, urology and vascular. This equates to circa 2.5% of the total population who may be affected by this business case annually. This percentage is set to increase and in order to respond to and effectively manage increasing demand for secondary care the current service model will need to change.
- Implications for NHS Tayside mean that we will see the need to create more capacity to meet demand for elective and unscheduled surgical procedures especially as the population changes and demand for some types of surgical services outstrip current capacity.
- Minority communities will need to be considered in options that change unscheduled service access or elective services and will be part of an engagement plan that is developed on the basis of an Equality and Diversity Impact Assessment.

NHS Tayside Services- Current State

1.8 NHS Tayside Overview

NHS Tayside is responsible for delivering healthcare to around 500,000 people living in Tayside. In Tayside, there are 80,000 admissions, 17,000 'same' day procedures, and 280,000 outpatient clinic sessions per annum. There are three main hospital sites: Ninewells, Perth Royal Infirmary and Stracathro.

The annual budget is circa £852 million which works out at around £2.3 million spent by NHS Tayside for every day of the year.

1.9 In scope Services Overview – Current state/status quo

The surgical services in scope of this business case are General Surgery, Vascular and Urology. Unscheduled and Elective surgical care is currently delivered on two sites; NWH and PRI. Elective care is delivered on three sites NWH, PRI and SRTC.

NWH is an 836 bed teaching hospital on the west side of Dundee. Unscheduled surgical care is provided via a dedicated acute surgical receiving unit (ASRU, Ward 7 24 beds). The

hospital services are used by people from Dundee, Perth and Kinross, Angus and North East Fife. The hospital also hosts a Regional Vascular Service for Tayside and Fife.

NWH

The number of beds for General surgery is 78 (Wards 8, 10 and 11) vascular surgery 24 beds (Ward 12) and Urology 18 beds (Ward 9). The inpatient beds are complimented by a large dedicated day surgery unit and theatre admission suite. NWH receives unscheduled admissions on a 24 hour, 365 day basis. There is on-site access to a broad range of specialist and subspecialist teams and services that support delivery of General Surgery; Upper Gastrointestinal, Hepato-Billiary, Lower Gastrointestinal, Vascular, Urology, Gynaecology and Interventional Radiology. There are 18 consultants supporting delivery of general surgery and subspecialty care supported by a number of consultant led teams in Anaesthesia separately covering operating theatre related care and Critical Care. There is an Acute Surgical Receiving Unit separate from elective services and a dedicated manned 24 hour theatre, acronymically named CEPOD ([54]Confidential Enquiry into Perioperative Deaths). Ninewells has 14 main operating theatres (including CEPOD) and three temporary theatres of which General Surgery has 38 theatre sessions per week and Urology 10 sessions per week. Access to theatre for unscheduled surgery (CEPOD) is provided routinely 08.00 hours up to midnight and via on call arrangement with one general surgical consultant on call from midnight to 08.00 hours. Ninewells has significant volumes of out-of-hours[55] unscheduled cases making up to 30% of case hours in the hospital.

PRI

PRI is located approximately one mile from Perth city centre and approximately 21 miles south from Ninewells Hospital. It offers services primarily to the Perth and Kinross population.

PRI has 201 beds of which 30 beds (Ward 1) are for elective General Surgery and a limited spectrum of unscheduled surgery. There are 6 surgeons based in PRI and a number of consultants “visiting” to undertake subspecialty work (theatre lists or outpatient/endoscopy) daily i.e. urology services. Unscheduled care for general surgery and non life-threatening Urology[56] is available in PRI Monday to Friday 08.00 - 21.00 and operates as an on call system weekdays and for those requiring unscheduled surgery Friday evening (17.00 hours) to Monday (08.00 hours) provided on a bypass arrangement to Ninewells hospital. This was implemented in 2011 for patient safety reasons with respect to medical cover arrangements. Unscheduled surgery theatre lists (CEPOD) are available in the afternoons Monday to Thursday and Friday morning.

Patients who are admitted out-of-hours during the week, if they do not require immediate intervention, may displace elective patients on elective lists the following morning. If surgery can wait until the afternoon they can be placed on a dedicated general surgical CEPOD list between 13.00 – 16:30 hours. The small numbers of patients who require overnight major surgery are transferred to NWH after stabilisation. This is due to the lack of a full surgical team to provide theatre and postoperative care. On weekdays out-of-hours general surgical patients share a single CEPOD theatre with orthopaedics. The out-of-hours nursing theatre team is non-resident and called in from home if required. As there is no Acute Surgical Receiving Unit, unscheduled surgical service on the PRI site is delivered from the 30 bed surgical ward.

[54] http://www.ncepod.org.uk/classification.html
[55] *Out of hours:* 18:00 hrs to 07:59 hrs Monday to Friday and all day Saturday and Sunday as per reference guide http://www.isdscotland.org/Health-Topics/Quality-Indicators/National-Benchmarking-Project/National-Theatres-Project/Docs/Technical-Appendix.pdf
[56] Medico-legal concerns have been raised with respect to the urology admissions as not all the general surgeons have training or experience in the specialty.

Patient requiring surgical services related to Vascular Surgery, Urology, Paediatric Surgery, Gynaecology, Interventional Radiology, or Major Trauma access the services provided in NWH. There is one Consultant General Surgeon and one Consultant Anaesthetist available in PRI on call overnight. The latter has responsibility for both theatre work and critical care. Some of the issues related to bed availability that affect PRI and NWH are more acutely felt in the former due to its smaller size and centre on delayed discharge. There is a joint Health and Social Care capacity and flow programme underway to help address this issue and facilitate ring fenced surgical capacity.

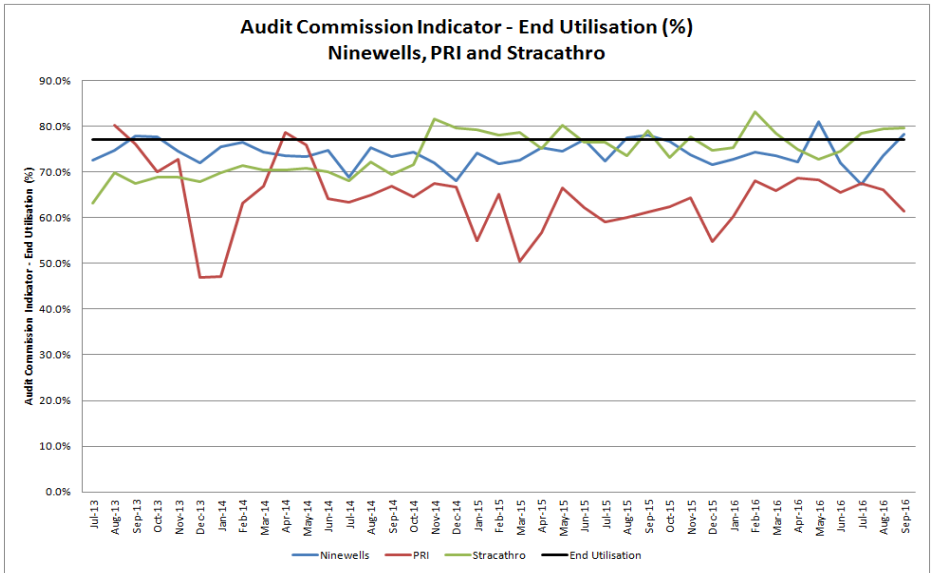
PRI has 15 theatre sessions for general surgery and a dedicated day surgery unit where elective day case urology and general surgery is carried out. PRI does not have interventional radiology services.

SRTC

SRTC is located approximately 35 miles north of Dundee and is a Regional Treatment Centre and caters for NHS patients from across NHS Tayside, Grampian & Fife. It provides 16 inpatient beds for non complex elective surgery. SRTC provides services for people who are generally fit and well who require day case surgery or surgery requiring an overnight stay Monday to Saturday morning only. All patients are required to meet criteria for surgical intervention on this site. Stracathro has diagnostic services for CT, Ultrasound and X-ray in hours only primarily servicing outpatient care and has no critical care facilities. Theatre capacity operates in the daytime only (1 theatre, 7 lists) and any patient requiring return to theatre or critical care is transferred to Ninewells by emergency ambulance.

Current data highlights that significant improvement to theatre utilisation to reduce waste and variation is required across all three hospital sites. Audit Commission (2006) [57]suggest an end use target utilisation rate 77%.

NHS Tayside has begun a programme of change using operations management science methodology in conjunction with a technical partner, the Institute for Healthcare Optimization (IHO) and the Scottish Government. This has given us the opportunity to review all of our main hospital sites to understand utilisation and clinical service delivery. The chart below shows current utilisation and demonstrates the significant under utilisation at PRI compared to SRTC and NWH:



[57]http://www.isdscotland.org/Health-Topics/Quality-Indicators/National-Benchmarking-Project/National-Theatres-Project/Docs/Final-Report.pdf

Of particular interest is how to balance resources and manage flows of time sensitive unscheduled or cancers cases and continue to deliver elective surgeries in line with treatment time guarantees and quality care. This work is split into two areas:

IHO 1

This work demonstrates that by improving care for unscheduled cases (CEPOD operating hours) and cancer cases ([58]Expedited) this reduces the daily operational challenges resulting from competing demands for unscheduled access to theatres and ensures time sensitive case are managed safely and appropriately using an urgency classification system. This also has the potential to improve overall length of stay and the patient experience of care by ensuring more timely access to theatres.

IHO 2

This work focuses on ways to further improve quality and safety of care on our surgical wards by smoothing elective surgical flow to and having a balanced number of surgeries each day.

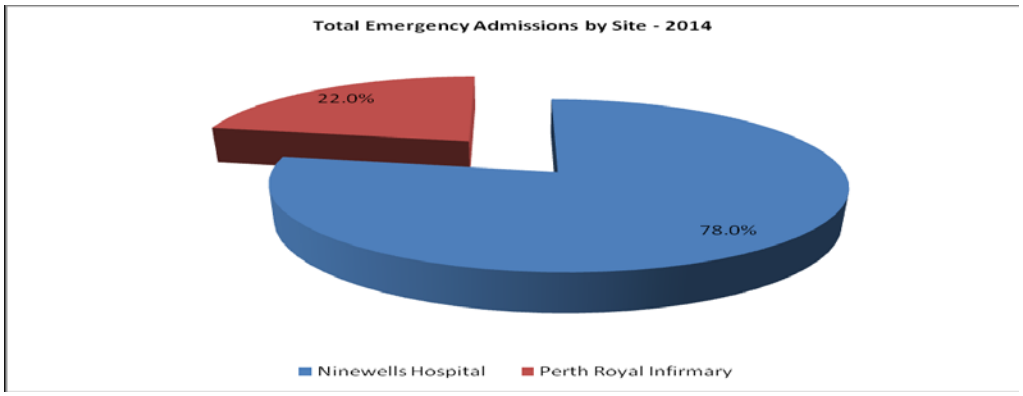
These changes are complex, but they are based on evidence and have considerable potential to improve outcomes for patients while at the same time maximising resources and clinical skills. These changes can only be achieved if NHS Tayside can separate elective and unscheduled flows on both its main hospital sites through the development of acute surgical receiving models that concentrate resources around patients to provide safe care and ensure elective capacity and activity is not compromised. The status quo will not be able to deliver the changes, the detail and rationale of which will be discussed throughout this case.

1.10 Demand for surgical services

Between October 2014 and September 2015, there were 4,127 elective surgical inpatient admissions and 8,549 unscheduled surgical admissions into NHS Tayside for General Surgery, Urology and Vascular surgery.

The chart below shows that total number of unscheduled admissions by site over the same period. 22% of patients were admitted to PRI and 78% were admitted to NW.

Total Inpatient Unscheduled Admissions by Site, General Surgery, Urology and Vascular *Oct 2014 – Sept 2015: Source Topas*

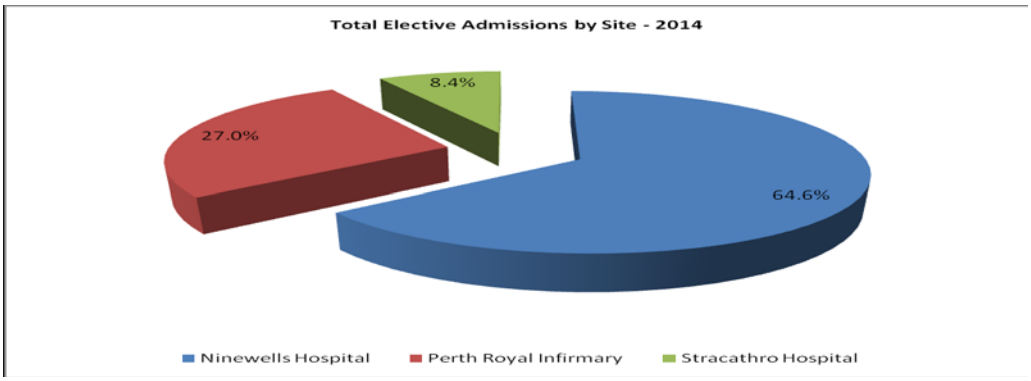


[58] *Expedited:* Stable patient requiring early intervention for a condition that is not an immediate threat to life, limb or organ survival. Target time to theatre is within days of decision to operate. ISD.

- As highlighted previously general surgery is currently the only specialty utilising PRI for unscheduled surgical patients. This is because of the limited availability of out-of-hours theatres and the lack of support resources to manage CEPOD cases e.g. interventional radiology & specialist support.
- Not all General Surgery patients who are Perth and Kinross residents will have their unscheduled care procedure at PRI. This is because some cases cannot be done at PRI due to case severity and resources required to deliver safe clinical care (see above).
- PRI has permanent bypass arrangements for weekend where all unscheduled surgical patients come to Ninewells from 17.00 Friday to 08.00 Monday. This was established in 2011 due to concerns about safe medical cover arrangements.
- No vascular or urology unscheduled work is carried out at PRI due to access to supporting resource only available on the Ninewells site.

The following chart shows the split of elective admissions and demonstrates numbers per site.

Total Inpatient Elective Admissions by Site, General Surgery, Urology and Vascular
Oct 2014 – Sept 2015: source Topas



- 68% of inpatient elective admissions were to NWH, 24% to PRI and 8% to SRTC.
- General Surgery performed 56% of the total volume of all their day case procedures within Stracathro and for Urology it was 81% total volume. This demonstrates the significant use of the SRTC site for day case procedures compared to other hospital sites.

Stracathro can only be used for patients who are clinically appropriate i.e. generally fit and well as there are no critical care facilities on site.

- Vascular Surgery can only be carried out in NWH due to access to supporting infrastructure and resources only available on the NWH site.

The following chapters will now illustrate the case for change.

Part 2

2.0 The Case for Change – Scope and Nature of Care

There have been a number of reports concerning the provision of unscheduled surgical care and service reconfiguration in the last few years; [59] RCS (2011) '*Emergency Surgery: Standards of unscheduled surgical care, Guidance for providers, commissioners and service planners*' and [60]'*Issues in Professional Practice: Emergency General Surgery*', Association of Surgeons of Great Britain and Ireland (2012). The [61]King's Fund (2014) also published an evidence guide *'The Reconfiguration of Clinical Services: What is the evidence?* 'This covered a number of services including 'Acute Surgical Services' in pages 50-54. There was also a further 'briefing' by the King's Fund in 2014; '[62]*Reconfiguring hospital services'.*

On a broader theme in Scotland the Chief Medical Officer's Annual Report 2014-15 '[63]*Realistic Medicine'* encompasses many of the broader themes running through the issues surrounding the challenges related to the provision of surgical services. The report described a '[64]House of Care' model the most pertinent part being that organisational processes and arrangements are built on a foundation of responsive allocation of resources or in other words, the highest possible care within an efficient cost framework. More specifically there were concerns in the report about variations in the practice and provision of services. This in turn may affect the management of risk that such differences may cause. Finally there was a specific call to change practice to support improvement; these:

'.....*are often dependent upon having the right conditions in place*'.

In any reconfiguration of hospital services there are four interlinked drivers: *quality* (including safety), *workforce*, *access* and *cost*. The challenge is to try to arrive at a configuration that optimises all these elements, as far as this is possible given the complex trade-offs that exist between them and the need to balance resources across unscheduled and scheduled care in order to achieve the highest quality of care. Quality considerations include timely access to highly trained professionals in all disciplines, compliance with clinical guidelines, access to diagnostic and interventional technologies, access to other support services and strong clinical governance. For some conditions, the time it takes to access these services will also be an indicator of quality.

2.1 Service Gap

This section considers the case for change by highlighting the gaps in current service provision and service standards and demonstrates why change is required.

---

[59] *Emergency Surgery: Standards of unscheduled surgical care, Guidance for providers, commissioners and service planners*', Royal College of Surgeons of England (RCS), February 2011,

[60] *'Issues in Professional Practice: Emergency General Surgery*', Association of Surgeons of Great Britain and Ireland. May 2012

[61] The King's Fund (2014) *'The Reconfiguration of Clinical Services: What is the evidence?*' .

[62] www.**kingsfund**.org.uk/.../**briefing**-on-reconfiguring-**hospital**-services- candace-imison-**kings**-**fund**-september-**2011**.pdf.

[63] www.gov.scot/Resource/0049/00492520.pdf.

[64] The house of care metaphor is used to illustrate the whole-system approach, emphasising the interdependency of each part and the various components that need to be in place to hold it together. www.kingsfund.org.uk/.../delivering-better-services-for-people-with-long- term-conditions.pdf.

The following graphic outlines the current balance of elective and unscheduled services for General surgery and Urology across PRI and NWH. SRTC is not shown as there will be no changes other than increased optimisation of current capacity.

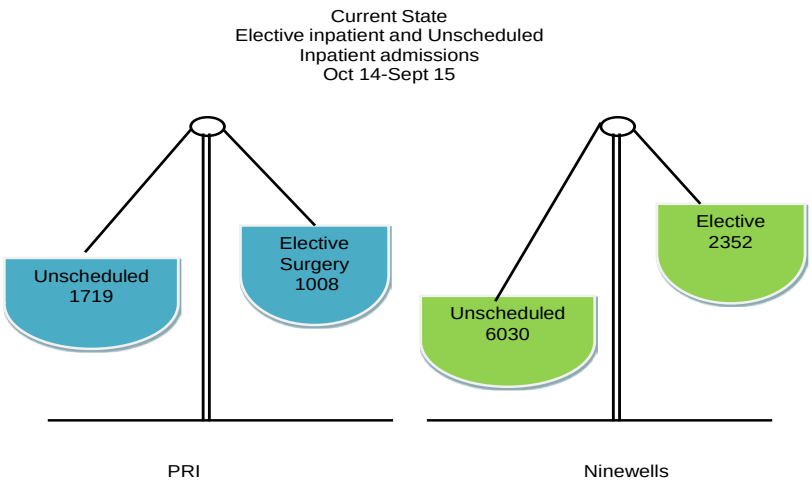
Note: The figures below only include and refer to General Surgery and Urology, October 2014 – September 2015

PRI Scales

- Unscheduled: 1,719 – This is all emergency admissions to PRI. PRI does not currently admit emergency patients at the weekend; therefore all emergency admissions are to Ninewells at these times.
- Elective: 1,008 – This is all elective admissions to PRI.

Ninewells Scales

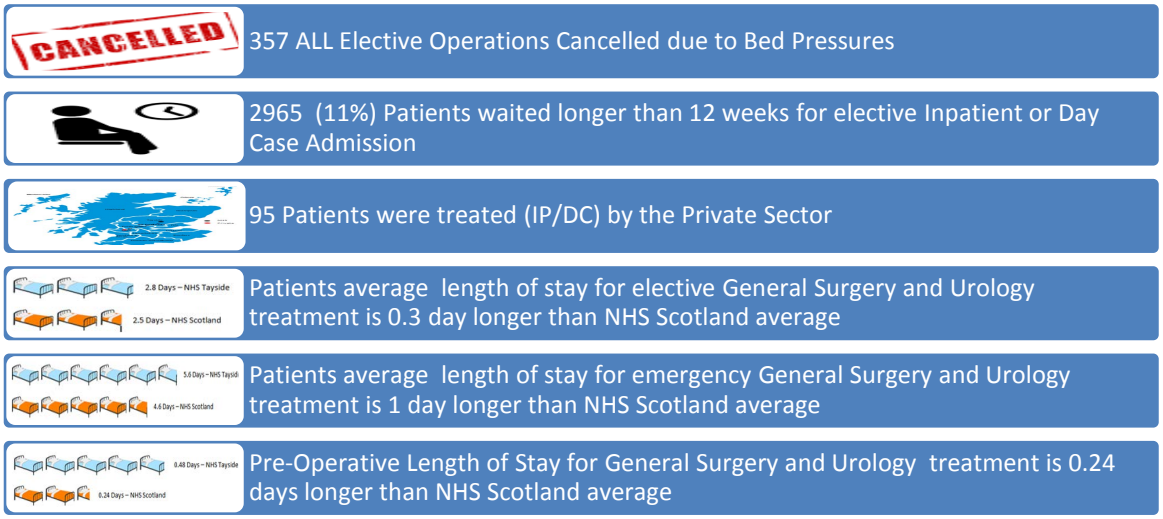
- Unscheduled: 6030 – This is all emergency admissions to Ninewells over 7 days.
- Elective: 2352 – This is all elective admissions to Ninewells.



The Cabinet Secretary for Health, Wellbeing and Sport said in response to healthcare delivery for the future that: "We fundamentally agree with the proposition that we need to change and evolve our health and social care services to meet rising demand, tackle health inequalities and meet the challenges of an ageing population" ([65]2015). The ability to deliver services under the current service configuration is challenging for a number of reasons such as our ability to maintain a safe and sustainable workforce, meet statutory treatment time guarantees and comply with the theatre classification system for Unscheduled CEPOD. This is set against a backdrop of increasing demand for elective and unscheduled services for patients.

[65] http://www.bbc.co.uk/news/uk-scotland-scotland-politics-32998161

The following chart demonstrates some of headline challenges in 2015/16:



The key drivers for SSS are therefore related to the provision of a safe and effective unscheduled care service in the context of significant medical workforce challenges. The variation from national benchmarks describes the variation that needs to be tackled by addressing the underlying causes for longer lengths of stay such as access to senior decision maker out-of-hours and access to diagnostic tests which delays decision to treat times, for example if you are admitted to PRI for appendicectomy you will have a length of stay on average 4 days longer than if you were admitted to NWH[66]. Furthermore the provision of unscheduled care on two acute hospital sites impacts adversely on the elective patient pathway of care with competing demands for inpatient beds leading to cancelled elective surgery. There were a total of 172 elective cancellations due to bed pressures for General Surgery and Urology over the period 09/01/2015 – 02/09/2016. This included both PRI and Ninewells. This is because unscheduled care patients will always take precedence over elective surgical care. These issues are explained in more detail in the following sections.

2.2 Maintaining a Safe and Sustainable Workforce

Workforce

A compelling driver for reconfiguration of services in many health boards is their capacity to provide junior and senior medical cover 24/7 ([67]King's Fund Briefing, 2011). Workforce challenges have become more explicit over the last few years specifically with changes to working times in European Law. On 1 August 2004 doctors in training in the NHS were no longer excluded from the provisions of the [68]European Working Time Directive. Their working hours are now limited by law to 48 hours. This legislation necessitated profound

[66] Source TOPAS length of stay unscheduled cases 2015/16
[67] www.**kingsfund**.org.uk/.../**briefing**-on-reconfiguring-**hospital**-services- candace-imison-**kings**-**fund**-september-**2011**.pdf
[68] Council Directive 93/104/EC. Official Journal of the European Community. 1993;L307:18–24

changes to working conditions for doctors in training. The [69]*RCS report (2011) states that:*

'the reduction in working hours for trainees has led to a decrease in their level of experience and this now impacts critically on consultant workload and service provision. It is vital that providers, planners and commissioners recognise that these changes require more senior (consultant) input early in the patient pathway in order to maximise patient outcome.'

Since 2011, safety issues relating to medical workforce led to the current configuration of surgical services in that unscheduled surgical care on the PRI site can be provided on a Monday – Friday model only. Despite this the medical workforce model remains fragile with increasing frequency of invoking business continuity plans to divert unscheduled surgical care from PRI to NWH in the out of hours period. This is likely to occur more frequently given the changes to doctors in training numbers and working conditions if we do not act now to change the model of service delivery.

In addition, workforce challenges are also affecting Consultant Grade posts. An analysis of the NHS Tayside senior medical workforce in surgical services shows that many will reach retirement age within the next 5 years at a time in which the recruitment climate is difficult. Workforce challenges are a considerable issue with many hospitals in Scotland struggling to fill vacancies for consultant posts with the national vacancy rate standing at 8.3% in 2015. Locum posts are in place to maintain services; however an over-reliance on locum posts is costly and is not a sustainable long term solution for NHS Tayside. The workforce challenges are not only related to medical staffing. Although NHS Scotland has had an increase in nursing and midwifery staff the vacancy rate in NHS Scotland is now almost 4%[70].

The continued use of locum doctors and agency nursing staff to manage workforce gaps places pressure on our commitment to deliver safe care, with a sustainable workforce and delivery of financial balance.

Maintaining a highly skilled and resilient workforce is essential to the delivery of safe clinical care. Studies have shown that the intervention of senior clinical decision makers early in the patient's pathway improves outcomes for patients and makes more efficient use of resources[71,72]. A lack of early consultant involvement in the assessment of unscheduled surgical patients leads to poor outcomes[73,74].

Increasing pressure of unscheduled workload on surgeons within NWH, combined with the need to improve times to theatre for the patients with the highest bands of severity score identified by recent work with IHO, requires a re-design of theatres and clinical workforce. The work by IHO demonstrates the requirement for an increase in the number of theatres (up to a total of 3) to facilitate the faster treatment of

National vacancy rate for consultant posts at 8.3%in 2015 and nursing and midwifery staff the vacancy rate at 4%.

[69] Royal College of Surgeons of England (RCS), February 2011, and *'Issues in Professional Practice: Emergency General Surgery*'

[70] www.audit-**scotland**.gov.uk/uploads/.../nr_151022_**nhs**_overview.pdf

71 Anderson I, Krysztopik R, Cripps N. *Emergency General Surgery Survey*. London:ASGBI; 2010.

59 McNeill G, Brahmbhatt DH, Prevost AT, Trepte NJ. What is the effect of a consultant presence in an acute medical unit? *Clin Med* 2009; 9: 214–218.

73 Wilkinson K, Martin IC, Gough MJ, Stewart JAD, Lucas SB, Freeth H, Bull B, Mason M (2010). An age old problem: a review of the care received by elderly patients undergoing surgery. London: National Confidential Enquiry into Patient Outcome and Death.

74 Martin S, Purkayastha S, Massey R, Paraskava P, Tekkis P, Kneebone R, Darzi A (2007). 'The surgical care practitioner: a feasible alternative. Results of a prospective 4-year audit at St. Mary's Hospital Trust, London'. Annals of the Royal College of Surgeons of England, 2007, vol 89, pp 30–35).

very sick patients and to reduce the case backlog stretching into the evening and night. In turn this would require 2 consultants working together, assessing and treating unscheduled patients referred into the hospital and from other in patient services (e.g. paediatrics). This would ensure rapid discharge of those patients who do not require an inpatient admission or who do not require surgery and also support those recovering from surgery.

The current configuration of services results in duplication at consultant level, vulnerable middle grade staffing rotas which require the use of locum agencies to support them, often at short notice, or which lead to rota breaches with significant unbudgeted expense as a result.

NHS Tayside places a high priority on looking at all solutions including developing strategies around workforce models and recruitment and retention to deliver safe sustainable service into the future. NHS Tayside is committed to valuing staff and creating the conditions for effective recruitment and retention of the workforce.

Training & Education

NHS Tayside hosts a medical school and nursing school at NWH. Doctors in Training and nurses in education and learning are a central part of our workforce makeup. Important facets for doctors in training within Tayside are the opportunities they have for education and learning, which must run in parallel with service provision. The General Medical Council regulates all stages of medical training and professional development, both undergraduate and postgraduate. An annual training survey by the regulator assesses the quality of training programmes to ensure a safe learning environment for doctors in training. Currently NHS Tayside is at risk of failing to meet the required standards. Also important is the quality and nature of the work experience. The changes in General Surgical unscheduled care delivery across our two main sites means that the nature of training opportunities is not able to be consistent across all hospital sites. For example at PRI opportunities for supervision in unscheduled surgical care cannot be secured at the weekend or into the evening. This cannot be sustained as NHS Tayside wishes to provide the highest possible trainee experience for all of our trainees wherever they are based.

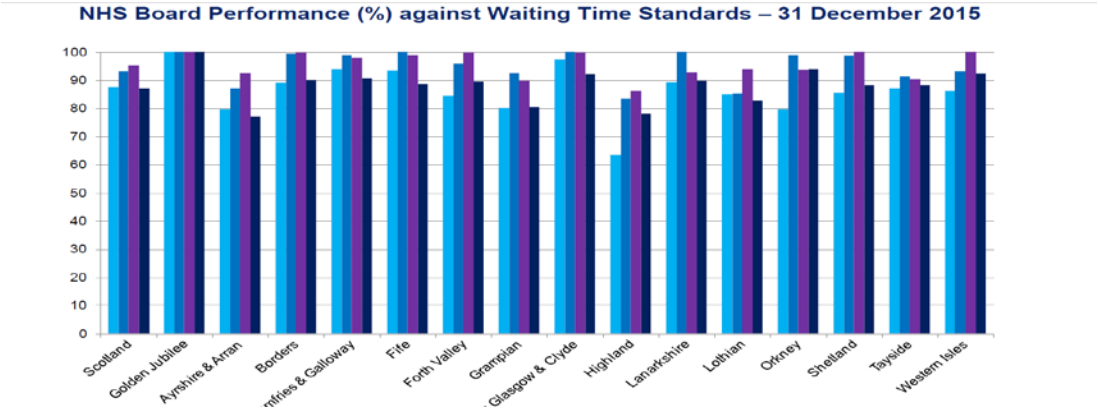
If NHS Tayside wishes to continue as a significant teaching centre we will need to consider how training can be delivered equitably across all of our sites and current shortfalls in trainee experience and supervision opportunities are more easily delivered through separating elective and unscheduled care.

2.3 Delivering the Treatment Time Guarantee

The Patient Rights (Scotland) Act 2011[75] establishes a 12 week maximum waiting time for the treatment of all eligible patients who are due to receive planned treatment delivered on an inpatient or day case basis. NHS Tayside does not consistently meet this guarantee. In NHS Scotland 95.2% of patients were seen within the 12 week Treatment Time Guarantee (TTG) for quarter ending 31 December 2015. This compares to 94.6% during quarter ending 30 September 2015 and 97.1% during quarter ending 31 December 2014.

The NHS Tayside position is charted below and highlights the waiting times challenges. The coloured bars relate to successive years with 87.1% of patients seen within the [76]18 week Referral to Treatment standard during month ending 31 December 2015 (dark blue bar). This compares to 87.2% seen during month ending 30 September 2015 and 88.6% during month ending 31 December 2014.

[75] www.legislation.gov.uk/asp/**2011**/5/pdfs/asp_**2011**0005_en.pdf
[76] The standard for delivery from December 2011 is for 90 per cent of patients to wait no longer than **18 weeks** from **referral to treatment**. www.gov.scot/.../NHS**Scotland**performance/**18weeksRTTS**tandard



The challenges of meeting Treatment Time Guarantees in NHS Tayside are compounded by fluctuations in demand for unscheduled care across the two main hospital sites resulting in cancellation of elective surgery. In order to mitigate against cancelled surgery, patients are often cared for out with their specialty ward for non clinical reasons i.e. [77] "boarding". There is emerging evidence (Beckett, 2014)[78] of the adverse impact upon the patient experience and safety relating to "boarding". There is also a significant amount of "bed days" capacity lost due to medical patients requiring beds within the surgical ward at PRI. There is evidence of some seasonal variation in the average number of bed days lost per month due to boarding over the past 21 months. The amount of surgical boarding remains low with medical boarding more prevalent in PRI and NWH. This peaked in March 2015 with a high of 40 beds days although the average has decreased steadily over the last 5 months from February (31 days) to June 2016 (12 days). [79]Delayed discharges remain one of the main factors that impact upon capacity and flow and are most acute within PRI where in a smaller site demand fluctuations have a larger impact as variation is not easily absorbed. In the 3 months (Apr-Jun 2016) the average number of patients experiencing a delay each month was 48 compared to 36 over the same period in 2015, and the number of bed days lost in the past 3 months was 1353 (equivalent of 14.9 beds) an increase of 357 bed days from 996 (equivalent of 10.9 beds) in the same period in 2015. This results in the TTG targets not being met and poor quality patient experience. Although significant improvement work is underway to reduce the impact of "boarding" and delays to discharge the effects on surgery will remain as long as there is competing demand for unscheduled patients versus elective surgical bed capacity.

Successive winter periods from 2013 onwards have seen cancellation of elective surgeries as a theme which were related to bed capacity or other non clinical reasons (figure includes orthopaedics cancellations). There were a total of 172 elective cancellations due to bed pressures for General Surgery and Urology over the period 09/01/2015 – 02/09/2016. This included both PRI and Ninewells. This cannot continue as a recurring theme for a number of reasons but in particular cancelling and rescheduling elective surgery causes inconvenience and worry to patients and significant frustration to clinical staff. Patients are very consistent about their expectations of hospital services ([80] Coulter 2005, Jha et al 2008, and Issac et al

[77] A patient who occupies a borrowed bed is described as boarding. This includes patients in beds who are managed by an individual consultant/team outwith the main allocated inpatient area for that consultant/ patient specialty or transferred to any non-inpatient bedded area (for example day units).

[78] www.acutemedicine.org.uk/.../Plenary-5-1030-Wrong-Place-Anytime-Why.

[79] A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available, for example to purchase a care home place.

[80] *What do patients and the public want from primary care? Angela Coulter BMJ 2005;331;1199-1201* Jha, A,K. et al (2008) Patients' Perception of Hospital Care in the United States. The New England Journal of Medicine. 359:1921-1931. October

2010). They want to see someone who knows what is wrong with them and can explain. They want someone who knows what to do and can make it happen. They want people who communicate effectively and are sensitive to their privacy and personal needs and they want to be cared for in a clean and dignified environment.

Significantly the lost capacity in theatre lists creates a waiting time backlog that has associated costs and quality, for example 95 patients were sent out with NHS Tayside for their surgery as the "lost" capacity cannot be recovered. There are also major fiscal consequences as when elective theatres are stood down on the day, the surgeon, anaesthetist and theatre team are also stood down at a cost of £967 per session to NHS Tayside which is not recoverable. The patient still requires their surgery to be done which means an additional session is required or alternative arrangements made to facilitate treatment out with NHS Tayside, incurring the cost again. This is clearly an inefficient model of care in a climate of financially challenged public services.

The competing demand between unscheduled and elective cases requires a fundamental shift in service delivery model to ensure an appropriate elective service and experience for patients. There is clear evidence from our IHO work that the separation of these two patient flows is a critical factor in delivering a balanced elective and unscheduled patient capacity management plan that can manage patient flow 365 days of the year.

2.4 Separating Elective and Unscheduled Care

Unscheduled Surgery (Emergency)

UK wide, unscheduled surgical admissions have increased by 47% growing over the last 15 years, with 20% on average requiring surgical review or admission ([81]Royal College of Emergency Medicine) and unscheduled anaesthesia and surgery make up an estimated 40–50% of the surgical workload in the UK ([82]Royal College of Anaesthetists, 2014).

There has been a steady build-up of pressure on the delivery of unscheduled care for surgical patients. There are a number of surgical conditions that increase with an ageing population and furthermore the complexity of surgery increases along with the likelihood of co-morbidities associated with stoke, hypertension, diabetes etc.

NHS Tayside has already embarked upon a series of changes through the IHO work that has the potential to transform how unscheduled care is delivered in the two main sites (PRI & NWH). The site option chosen will be pivotal in achieving maximum outcomes associated with the key objectives of the IHO work and critical to that is the separation of elective and unscheduled surgical care. This is reinforced by commentary from national clinical bodies and leading commentators on policy and practice. The Royal College report on Emergency Surgery Guidance for providers, commissioners and service planners [83] (2011) Standards for unscheduled surgical care suggests that:

" … reconfiguration of services across hospital sites is likely to be the only way that some trusts can achieve financial balance… and (should) focus on achieving best practice outcomes and patient experience …"

2008 , Isaac, T. et al (2010) The Relationship between Patients' Perception of Care and Measures of Hospital Quality and Safety. Health Services Research. 45(4):1024-1040. 2010

[81] Emergency admissions to hospital: managing the demand, National Audit Office, 2013

[82] Royal College of Anaesthetists (2014). *Guidelines for the provision of anaesthetic services*. London: Royal College of Anaesthetists. Available at: www.rcoa.ac.uk/system/files/GPAS-2014-FULL_0.pdf

[83] www.**kingsfund**.org.uk/publications/**reconfiguring-hospital-services**

Whereas the Kings fund [84]concluded that:

" … there is increasing recognition that services such as emergency surgery may be unsafe out of hours and the provision of these services needs to be concentrated in fewer centres that are better able to provide senior medical cover …"

In NHS Tayside there has been a steady rise in the number of unscheduled surgical inpatient admissions. NHS Tayside saw 41,144 patients admitted as inpatient surgical "emergencies" across all specialties over 2014/15 (financial year April to March) at a rate of 9,943 per 100,000 per head of population. The number of unscheduled bed days (days used in each length of stay) used in Scotland has seen a gradual reduction from 4.11m in 2008/09 to 3.83m in 2013/14, however the number of unscheduled admissions (numbers of individual patients) has risen from 521,406 in 2008/09 to 542,805 in 2013/14 (source TOPAS).

Volume alone is not an indicator for change in surgical service delivery. The clinical argument provides an even more compelling case. Patients requiring unscheduled surgical management are among the sickest patients treated in the NHS and advanced age and significant co-morbidity are common in those requiring unscheduled surgery ([85]Association of Surgeons of Great Britain & Ireland, ASGBI, 2001).

It is widely accepted that the efficient and effective delivery of unscheduled surgical care is dependent upon the availability of experienced clinicians working together in teams to provide the best outcomes for patients and with adequate resources to do their work such as the right diagnostics support services or access to unscheduled theatres. Not all of our sites offering unscheduled surgery have access to a comprehensive interventional radiology service necessary to support unscheduled work safely ([86]ASGBI, 2012). PRI cannot offer the full range of specialties and treatment options that are available at NWH.

PRI does not currently deliver high volume out-of-hours unscheduled surgeries due to availability of onsite consultant resources in the out-of-hours period and weekends (out of hours cover is provided overnight weekdays). This is because unscheduled care services for general surgery were withdrawn in 2011 due to safety concerns over the ability to provide the necessary 24/7 surgical consultant and anaesthetist on site cover for major general surgical cases. Some types of unscheduled care pathways bypass PRI on a permanent basis due to the lack of availability of resources required for patient care and safety. Consequently NWH does have significant average and proportional volumes of unscheduled cases in the out-of-hours period (evening, overnight and weekend).

Data analysis (TOPAS, 2014/15) also shows that preoperative length of stay for unscheduled surgery can be increased by 0.5 days at PRI site for some types of unscheduled surgery compared to preoperative length of stay at Ninewells. This is related to theatre access, access to senior clinical decision maker and the model of unscheduled care service. Currently in PRI all unscheduled patients are admitted, unlike an acute surgical receiving model (i.e. in Ninewells) where not all patients will be admitted, a proportion will be assessed, investigated and discharged. Of the current admissions for unscheduled care 30% of patients do not require surgery. An Acute Surgical Receiving Unit (ASRU) model allows for the appropriate access, assessment and management of patients which is not currently available at PRI and results in longer lengths of preoperative stay. Data shows that the Pre-Operative Length of Stay for unscheduled General Surgery and Urology treatment is 0.24 days longer than NHS Scotland average (ISD, 2015/16). Recent benchmarking has

[84] www.**kingsfund**.org.uk/.../**transforming-the-delivery-of-health-and-social- care**-the-**kings**-**fund**-sep-**2012**.pdf.
[85] Association of Anaesthetists of Great Britain and Ireland. Anaesthesia and peri-operative care of the elderly. 2001. http://www.aagbi.org/sites/default/files/careelderly01.pdf
[86] Association of Surgeons of Great Britain and Ireland (2012) ISSUES INPROFESSIONAL PRACTICE. EMERGENCY GENERAL SURGERY

highlighted NHS Tayside as an outlier compared to other NHS Scotland Boards with regards to lengths of stay for unscheduled surgery and elective surgery. In NWH and PRI patient's average length of stay for unscheduled General Surgery and Urology treatment is 1 day longer than the NHS Scotland average. There is a need to:

- Improve the priority given to patients requiring unscheduled surgical care by separating elective and unscheduled care and ensuring access to 24/7 delivery of unscheduled surgical services,
- Improve the timeliness of unscheduled surgery into dedicated CEPOD theatres with associated infrastructure by effectively implementing a clinical urgency classification framework (IHO work),
- Understand best practice in peri-operative care in order to reduce morbidity and mortality.

The King's Fund [87](2014) summarised the evidence:

'*Acute surgical services should be supported by a dedicated emergency theatre, appropriate critical care services, acute medicine and diagnostic services, including interventional radiology".*

Outcomes for unscheduled surgery vary considerably between units. There is some evidence that hospitals which conduct higher volumes of surgery have better outcomes [88],[89](Urbach and Baxter 2004, Naylor R 2013), though the relationship is quite complex.

On a similar vein, a letter from the Presidents of The Academy of Medical Royal Colleges and others to [90]*The Guardian, 28 April 2010,* stated that:

'*…* there is increasing recognition that services such as surgery may be unsafe out of hours and the provision of these services needs to be concentrated in fewer centres*.'*

*The Royal College of Surgeons (2013) report, '*Reshaping surgical services: principles for change' reiterated that:

'.....where possible, major emergencies are centralised'.

The key resources needed for effective management of unscheduled surgery derived from the above reports are summarised below:

An Acute Surgical Receiving Unit providing focused streamlined resuscitation & assessment.
Separate unscheduled and elective services and beds.
Adequate theatre access: real, prioritised and staffed. Undertaking operations at any time, day or night
Adequate senior availability within job plans.
Surgeons with adequate skill sets.
Adequately staffed junior team.
On-call and team structure which provides support and continuity of care.
Adequate critical care facilities.
Access to skilled interventional radiology including out of hours.

[87] http://www.kingsfund.org.uk/publications/reconfiguration-clinical-services/summary/acute-surgical
88 Urbach DR, Baxter NN (2004). 'Does it matter what a hospital is "high volume" for? Specificity of hospital volume–outcome associations for surgical procedures: analysis of administrative data'. Quality & Safety in Health Care, vol 13, no 5, pp 379–83
[89] Naylor R, Wyatt M, Mitchell D. High volume surgery outcomes suggest there is safety in numbers. Health Service Journal; 8 March 2012.
[90] https://www.theguardian.com/society/2012/jul/24/terence-stephenson-doctors-nhs

In Tayside, though these key resources are available, their current distribution does mean that for some patients their journey-of-care and time to access treatments varies. Unfortunately, in many cases the individual patient's needs for care can only be known following inpatient assessment and therefore some of the sickest patients will be subject to a delay in the time to begin their definitive treatment. PRI cannot offer the full range of specialties and treatment options that are available in NWH (e.g. patients referred with abdominal or back pain being found to have a ruptured aortic aneurysm, patients whose best management would require Interventional Radiology) which means that Perth and Kinross residents already travel to NWH.

Access

A few studies suggest that greater distance to hospital is associated with an increased risk of mortality once illness severity has been taken into account. Nicholl et al (2007) found a 1% increase in mortality risk for each 10km increase in distance (*across a wide range of conditions, surgical and non-surgical*)[91]. However, it is critical to note that it is the timing of the start of appropriate treatment, rather than the time of arrival at hospital that affects the outcome, so interventions by paramedics, rapid assessment and/or rapid access to the appropriate specialist team once at the hospital offsets or overcomes the risk created by the additional travel time [92](Spurgeon 2010). This is important to note as the current configuration of unscheduled service within PRI does not have an ASRU streaming assessment and has limited access to CEPOD theatres thereby creating system related delays to patient access to theatres. There is therefore the concern that although a patient may get to hospital quicker their time to definitive care is not as quick as an optimised configuration could achieve.

Elective Surgery

Elective surgery was identified as a key area of concern by the National Framework Advisory Group ([93]Scottish Executive, 2004) and although the work focused on orthopaedics there are parallels with all elective surgery. Concerns include how to best streamline the hospital component of elective care, while ensuring good practice in assessing need and capacity planning. It is also important to understand the implications for the whole service if there is separation of unscheduled and elective care. The report strongly recommended the separation of unscheduled and elective flows and went further to recommend that NHS Scotland develops centres / facilities that deal only with elective care either on existing hospital sites or in new buildings.

More recently it was recognised that in order to deliver waiting time guarantees and safe surgical care NHS Scotland should invest in specialist elective treatment centres ([94]NHSScotland Clinical Strategy, 2015). Demand for elective surgery operations has increased by 60% between 1995 and 2013 (NHS data) and the case mix has risen for age related conditions such as cataract and hip and knee replacements. In October 2015 the Scottish Government announced six new elective treatment centres. These centres will allow patients to be treated more efficiently for planned surgery and the facilities will help the

---

[91] Nicholl J, West J, Goodacre S, Turner J (2007). 'The relationship between distance to hospital and patient mortality in emergencies'. *Emergency Medicine Journal*, vol 24, pp 665–68.

92 Spurgeon P, Cooke M, Fulop N, Walters R, West P, 6 P, Barwell F, Mazelan P (2010). *Evaluating Models of Service Delivery: Reconfiguration principle.* National Institute for Health Research Service Delivery and Organisation programme. London: HMSO.

[93] Scottish Executive (2005). A National Framework for Service Change in the NHS in Scotland. BUILDING A HEALTH SERVICE FIT FOR THE FUTURE.
[94] www.gov.scot/Publications/2016/02/8699

NHS meet increasing demand from a growing elderly population, taking pressure off unplanned and emergency treatment. Over £200 million will be invested to secure the centres across Scotland including in NHS Tayside.

The development of elective sites will take some time and requires NHS Tayside to act now to support high quality, safe and cost effective care to surgical patients and to plan effectively for the elective treatment centre in NHS Tayside. However an elective treatment centre alone will not deliver the capacity to meet the changing population demographics over the next 5-20 years. More effective use of current elective capacity as well as securing safe effective unscheduled care into the future is essential. This can only achieved by separating elective and unscheduled care flow and through delivering the recommendations with respect to CEPOD from the IHO work. The recommended option outlined in this OBC to separate elective and unscheduled care streams is the vehicle to ensuring the optimal design, configuration and availability of elective care services over the next three, five and ten years.

A report by the [95]RCS, '*Separating emergency and elective care: Recommendations in practice'* (2007) echoed the same principle. More specifically it recommended a physical separation of (unscheduled and elective) services and facilities. The report went to say:

- The separation of unscheduled and elective surgical care can facilitate protected and concentrated training for surgeons in training,
- Separating unscheduled and elective services can prevent the admission of unscheduled patients (both medical and surgical) from disrupting planned activity and vice versa, thus minimising patient inconvenience and maximising productivity for the Trust,
- Hospital-acquired infections can be reduced by the provision of protected elective wards and avoiding admissions from the emergency department and transfers from within/outside the hospital.

This view was reinforced by the [96]RCS in written evidence to the Health Select Committee of the Westminster Parliament, (September 2013):

'The College believes that, when carefully planned and adequately resourced, the separation of unplanned emergency and planned elective services will improve the quality and safety of care delivered to patients.'

In line with the above, on the PRI site there is daily variability in the delivery of elective care driven by the pressure to manage unscheduled and elective cases within the same flows. As our current operating model involves the provision of unscheduled care on two hospital sites this daily variability is also evident on the NWH site whereby unscheduled care will always take priority over elective surgical admissions. This has serious implications for the patient experience leading to short notice cancellation of elective surgery as other than SRTC which has strict elective admission criteria there is no other ring fenced elective facility.

Institute of Healthcare Optimization (IHO)

NHS Tayside is in the first tranche of Scottish Boards working with IHO. There are 2 IHO projects; to improve theatre access for unscheduled surgical patients (IHO 1) and to optimise the process of admission for elective care (IHO 2).

An urgency classification system has been developed to ensure that patients access theatre within clinically accepted wait times for their condition. This classification is in effect a standardised severity score of unscheduled surgical care.

[95] Royal college of Surgeons *(2007),Separating emergency and elective care: Recommendations in practice'*
[96] http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/171vw09.htm

IHO 1

The top 3 most urgent categories, which define the maximum time to theatre following the decision to operate for best outcomes for a particular patient, are 'A' cases <45 min; 'B' cases - < 2 hrs; 'C' cases - < 4 hrs. The compliance rate for these grades is shown below.

	PRI			NWH		
	No.	Day	Night	No.	Day	Night
A (<45 mins)	2	-	100%	35	60%	50
B (< 2 hours)	6	67%	80%	58	63%	84%
C (<4 hours)	8	100%	95%	108	73%	84%

The IHO study also reported that failure of compliance across all categories resulted in an increase in length of stay of 1.6 days. This in turn equates to a loss of 443 bed days / year. The report did not take into account delays in assessments and theatre booking.

In order that NHS Tayside creates a system to reliably deliver the system related performance required for unscheduled theatre access a redesign of current CEPOD configuration is essential. The theatre modelling scenarios presented by IHO required an increase in CEPOD availability of 2-3 theatres in NWH. This will require to be balanced with the impact of the effect on elective care. Following discussion with clinical staff it would seem appropriate to increase the number of consultants providing unscheduled surgical care on the NWH site within peak times. This would enable parallel assessment and operating by senior clinicians. In tandem the use of more than 1 CEPOD theatre would expedite high severity score patients and reduce overspill beyond core working time hours.

IHO 2

The main finding of IHO regarding PRI was that it is underutilised compared to NWH and by increasing elective utilisation there was the potential to significantly increase elective case volume at PRI.

In addition to improving actual theatre utilisation this would require 'smoothing' of elective admissions, spreading admissions more appropriately across the week, so reducing the likelihood of cancellations and the number of beds required to deliver elective surgical care. This in turn is best delivered in a system with greater separation of elective and unscheduled care.

Therefore the recent IHO work has also identified the need for improvements in the elective care service within Tayside. These need to be considered in the wider context of potential unscheduled care reconfiguration.

2.5 Maintaining Supporting Infrastructures for the Delivery of Elective and Unscheduled Surgery

Central to the delivery of any surgical care model is the provision of access to critical care facilities. Both hospital sites at PRI and NWH have critical care facilities. The proposed changes will require NHS Tayside to maintain critical care facilities across both our sites

and ensure occupancy standards are maintained in line with SICSAG standards ([97]Scottish Intensive Care Society, 2014). The recommended option will require optimisation of critical care in PRI and reshaping the critical care footprint on the PRI site to enhance flexibility across the levels of critical care. Perth ICU has occupancy of 57% with 56% of the admissions already being direct from theatre. This occupancy rate suggests that there is capacity available to further support peri-operative care delivery to support and increase in elective procedures.

There are 34 operating theatres across NHS Tayside located at PRI, NWH and SRTC. There are 8 theatres on the PRI site, 22 on the NWH site with the remaining 4 on the SRTC site. There is variation in theatre utilisation across the site and week on week. The reshaping of surgical services creates the opportunity to optimise the theatre usage across all sites reducing the need for outsourcing of surgery to the independent sector.

NHS Tayside has invested in additional theatre capacity to meet demand through the use of temporary mobile theatres. This model was implemented as a temporary measure initially for a 6 month period but has been ongoing. There are 3 temporary theatres supporting delivery of surgical care at a cost of £1,965,0000 per annum. IHO data is suggestive that we can reduce reliance and decommission these by improving theatre utilisation across all 3 sites and reconfiguring CEPOD theatres. The financial cost is significant but there are also quality implications. The use of temporary building structures to perform surgical procedures has imposed a number of restrictions when compared to a main theatre suite with respect to the type of surgery undertaken.

2.6 Summary

In summary there are a number of issues associated with current service model making the status quo an unviable option.

- The time to unscheduled surgery in the sickest patients.
    - Between 30-40% of such patients did not achieve the clinically agreed time to theatre.
    - This results in patients being sicker at the point of definitive treatment with consequent longer recovery times and higher risk of complications and even death.
    - In NWH the unscheduled demand can be greater than the ability of one unscheduled (CEPOD) operating theatre and one surgeon to deliver.
    - In PRI there is limited access to a CEPOD theatre as it is shared with Orthopaedics. This can result in either delay to surgery or interference with access of elective cases to theatre.

- The effect of unscheduled care on elective care delivery.
    - This leads to both short notice cancellations of elective admissions and day-of-surgery cancellations.
    - Patients who have taken time off work, organised care for those at home and come to terms with the need for and worries of submitting themselves to surgery are disappointed and inconvenienced.
      Plans by patients, relatives, clinicians and hospital can be severely disrupted

[97] www.**sicsag**.scot.nhs.uk/.../2015-08-11-**SICSAG**-Annual-Report.pdf?22 ***Audit of Critical Care in Scotland 2015 ,Reporting on 2014***

- The resilience of staffing and resource levels to deliver unscheduled surgical care.
    - There are on occasions overwhelming demands on unscheduled care in NWH. This is both in terms of pressure on staff and on theatres. It should be noted that currently about 1000 Perth and Kinross patients receive their unscheduled surgical care in NWH.
    - In NWH there is a pressing need to increase both staffing and theatres dedicated to unscheduled care.
    - In PRI a consultant and a doctor in training provide the overnight weekday service; there is no flexibility or resilience. A single absence can cause closure of the PRI service and transfer of unscheduled care to NWH.
    - Tayside currently operates 2 parallel rotas for surgical consultants delivering unscheduled care with CEPOD theatres on two sites with no cross over.

- Uncertainty in unscheduled care due to the distribution of specialty services within Tayside.
    - Currently a number of unscheduled care needs are focused on NWH due to resource needs (e.g. Vascular, Major Trauma and Interventional Radiology).
    - Patients from Perth and Kinross who are known to need these before or following admission are transferred either directly or indirectly to NWH.
    - It is not possible to provide these services on 2 sites within Tayside (and in the case of Vascular and Interventional Radiology, within Tayside and Fife).
    - Any patient who requires transfer from PRI will have an inbuilt delay to definitive treatment.

To achieve more, sustainability, resilience and certainty an option appraisal was carried out to ascertain whether there was a way of not only addressing some or all of these issues but also to improve the quality of care delivered to all patients (elective and unscheduled), across Tayside.

2.7 Measures of success

The following measures will be used in a post project evaluation to test delivery of quality of care standards and that performance measures are met as a result of the proposed changes:

Unscheduled care

- Timely access to a fully staffed emergency theatre
- Compliance with Acute Care standards (2010)
- Comprehensive assessment before admission to ensure most appropriate care
- Compliance against Emergency theatre classification framework
- Reduce post operative readmission
- Contribute to reduced longs lengths of stay (LOS)
- Operations that are carried out at night meet NCEPOD classifications and be under the direct supervision of a consultant surgeon.
- Critical care occupancy rate of 70% of the staffed beds (SICSAG, 2012)

Scheduled Care

- Improved patient experience & quality of care

- Increased elective care closer to patients home
- Reduction in unutilised theatre hours/unallocated theatre hours
- Reduction in cancellation of elective surgery
- Reduction in emergency cases in planned sessions
- Delivery of Treatment Time Guarantee (TTG) & Cancer Targets

2.8 Economic Case

Implicit in the SSS strategy is NHS Tayside's 5-year Transformation Programme. Investing to reach strategic goals is not simply about financial objectives but about a number of investment objectives to continue to deliver quality and safety, improve patient outcomes and patient experience whilst ensuring cost effective service delivery and financial balance.

The King's Fund report '[98]*Reconfiguring hospital services:* Lessons from South East London*', published in 2011* by Keith Palmer (a past Vice Chairman of NM Rothschild investment bank) suggested that hospitals should:

'*…focus on achieving best practice outcomes and patient experience … lower growth of hospital activity will result in excess capacity and stranded costs. Without reconfiguration, some financially challenged trusts will suffer a downward spiral of increasing deficits, declining quality of care and a further widening of the existing quality gap between the best and worst performers'.*

He summarised stating:

'reconfiguration of services across hospital sites is likely to be the only way that some (Heath Boards) can achieve financial balance'.

Cost is an ever-present issue. Previous Board papers have highlighted that NHS Tayside has an operating service model that extends beyond its budgeted financial allocation in terms of site configuration, workforce, medicines and operational costs. The OBC aims to support a move towards high quality cost efficient services that allow resources to be mapped to need, effective use of workforce assets and sustainable configuration of services to meet future demand.

The IHO work has clearly identified changes that are required to theatre utilisation and efficiency with a clear need to optimise all available capacity across the three main hospital sites and remove reliance on costly mobile theatre capacity.

The following investment objectives define the outcomes of shaping surgical services and underpin the options appraisal benefits criteria :

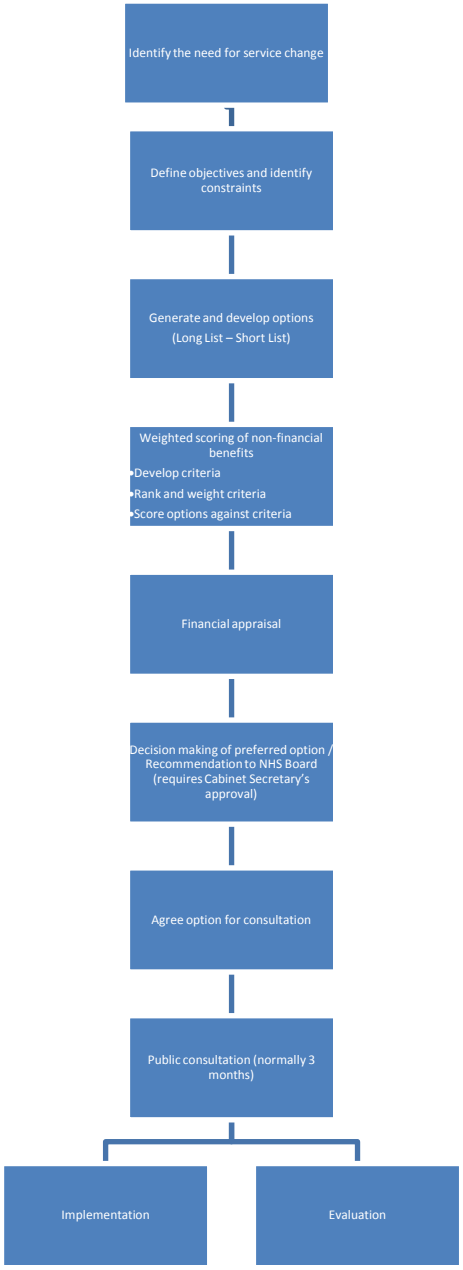
[98] www.**kingsfund**.org.uk/**publication**s/**reconfiguring-hospital-services**

Benefits criteria (options scoring)	Investment objectives
Optimised Unscheduled Model ***"Achieve optimum balance between emergency, urgent and elective care to maintain effective patient flow"***	The creation of **cost effective & efficient services** can be achieved by separating scheduled and unscheduled flows and through approaches to address artificial variability in patient flow, which is a key driver of cost, quality and access issues in healthcare, creating the foundation for determining the magnitude of resources for various patient streams.
Optimised Use of Accommodation & Footprint across NHS Tayside ***"Make the best use of resources at all three sites"***	Deliver a sustainable model for safe multiple site working- Allocation of all of our assets, staff and facilities is the key to safe **effective care** and through better use of all of our surgical sites to ensure surgical services are cost effective and meet the statutory waiting time guarantees. The aim is to optimise use of all assets by facilitating models where costs and volume can be meet current growth and changing population trends and in line the future establishment of elective treatment centres and be separating elective and unscheduled surgery.
Optimise Patient Pathways ***"Provide best opportunities to ensure anticipatory care planning"***	NHS Tayside must provide **safe and high quality care** at a reasonable cost with the ability to meet changes in demand through seasonal fluctuation and growing demand for surgical services especially for older people. Work with IHO the national Whole System Flow programme 1. optimise efficiency and productivity, 2. eliminate unnecessary variation, 3. improve patient and staff experience, 4. improve patient safety, and 5. reduce waste and inefficiencies Deliver all local and national targets meeting patient expectations.
Optimum Balance of Regional / Tertiary / Local Services ***"Deliver sustainable, safe & high quality multiple site working"***	Achieve a balance between emergency, urgent and elective care to maintain effective patient flow with consistent approach to care Co-ordinated approach to patient care
Generating closer links & collaborative working with Primary Care	Delivery of the 6 Ps - prepared patient, prepared pathway, prepared practitioner through Improved integration and

"Working together to provide a co-ordinated and complimentary approach to delivering end to end pathways for patients"	efficiency of surgical services
Potential for building a sustainable workforce providing continued development, education & training opportunities ***"Build capacity & capability to achieve sustainable change by attracting & retaining our workforce"***	**Investing in our services to deliver** sustainable care for the next decade and beyond **by investing in the workforce through research, innovations in care and providing a highly trained and resilient workforce.**
Providing opportunities for making IT & eHealth Work Better for Patients & Staff	***Identifying opportunities for improvement & joined up working***

A review of potential options has been carried out which included the baseline position. The summary below outlines the implications of the options considered and highlights the recommended option going forward**.** Option appraisal is a technique for setting objectives, creating and reviewing options and analysing their relative costs and benefits prior to implementing service change. This section documents the options appraisal exercise undertaken to determine the preferred option for the delivery of unscheduled and elective General Surgery, Urology and Vascular Surgery across the three acute sites - NWH, PRI and SRTC. The purpose of the appraisal was to evaluate the non-financial benefits across a number of site service delivery options.

The option appraisal involved generating a long list of options for service configuration; this was subsequently reduced to a short list of options, culminating in an exercise to determine the preferred option. The options appraisal was underpinned by a recognised evaluation process as outlined in the Scottish Capital Investment Manual – Guidance for Options Appraisal. The following schematic highlights the process applied to this exercise:-



2.9 The Long List of Options

A small group of operational and clinical staff were tasked with developing a range of possible site configurations for surgical services. There were 18 options (see appendices) initially identified, which were reduced to the following contained in section below:

Option 1	Not a feasible option – unable to resource all sites e.g. HDU, ICU, 24/7 Radiology Services
Option 2	Not a feasible option – insufficient resource / capacity to support three sites activity model e.g. HDU, ICU, 24/7 Radiology Services
Option 3	Not a feasible option – no interventional radiology in PRI for vascular surgery
Option 4	Not a feasible option – unable to undertake full range of cases for colorectal service in PRI due to co-dependency with Surgical Receiving and other Specialties
Option 7	Not a feasible option – insufficient capacity for single site to deliver all services
Option 8	Not a feasible option – insufficient capacity for single site to deliver all services

Option 9	Not a feasible option – insufficient capacity for single site to deliver all services
Option 10	Not a feasible option – insufficient resource / capacity to support three sites activity model
Option 11	Not a feasible option – insufficient resource / capacity to support three sites activity model
Option 12	Not a feasible option – insufficient resource / capacity to support three sites activity model

In summary the options above were discounted as these were not feasible due to major infrastructure issues and the capital resource that would be required to address these or were associated with the withdrawal of services from one or other of the three sites for example putting in place critical care facilities in SRTC will require major investment in facilities and staffing). The primary aim of SSS and the organisational commitment was to maintain surgical services on all three sites (options that included withdrawal of surgical service from a site were excluded), optimisation of site utilisation by increasing case volumes and supporting access for local communities.

A subsequent facilitated SSS workshop with Programme Board members was undertaken to reduce the long list to a short list of options. The remaining eight options were thus reduced to a short list of five options as these were effectively focused on specific elective surgical interventions as opposed to site service delivery.

2.10 The Short List of Options

The short list of options generated from the assessment of the long list of options is outlined below. The options were renamed from A to E for ease of reference and reduce ambiguity associated with an out of synchrony numbered list. For ease of reading Board Members should note that Option A was an amalgamation of the long list numbers 6, 15 and 17 on the basis that these were variations of the same site configuration.
The short list of options is outlined in the table below:-

Option	Narrative	PRI	Ninewells	Stracathro
(A) 6,15,17	General Surgery, Urology & low risk Vascular (access & veins) surgery delivered on PRI site. Single site SRU in Ninewells, together with all unplanned and major surgery for all in scope services. All in scope elective (day case) services delivered on Stracathro site, including low risk vascular (veins).	ELECTIVE (inc. major) General Surgery & Urology with low risk Vascular (access & veins)	SRU (inc. all unplanned surgery) ELECTIVE (major) General Surgery, Urology and Vascular	ELECTIVE (day case) low risk Vascular (veins)
(B) 13	Service Provision as delivered currently. (STATUS QUO)	SRU (Monday to Friday only) (inc. unplanned surgery), General Surgery & Urology ELECTIVE (inc. major), General Surgery & Urology	SRU (inc. unplanned surgery) General Surgery, Urology and Vascular ELECTIVE (inc. major) General Surgery, Urology and Vascular	ELECTIVE (day case) General Surgery & Urology
(C)	Service Provision as delivered currently, with SRU	SRU (day time only) (inc. unplanned	SRU (inc. unplanned surgery)	ELECTIVE (day case)

14	in PRI (day time only).	surgery), General Surgery & Urology ELECTIVE (inc. major), General Surgery & Urology	General Surgery, Urology and Vascular ELECTIVE (inc. major)General Surgery, Urology and Vascular	General Surgery & Urology
(D) 18	Service Provision as delivered currently, with SRU in PRI 24/7.	SRU (24/7) (inc. unplanned surgery), General Surgery & Urology ELECTIVE (inc. major), General Surgery & Urology	SRU (inc. unplanned surgery) General Surgery, Urology and Vascular ELECTIVE (inc. major) General surgery, urology & Vascular	ELECTIVE (day case) General Surgery & Urology
(E) 16	Colorectal & Urology elective surgery only delivered PRI site. Single site SRU in Ninewells, together with all Hepato-Billiary, UGI & Vascular surgery, planned & unplanned surgery for Urology, & all unplanned surgery for colorectal. Elective day case for general surgery & urology in SRTC	Colorectal & Urology (Elective only), with appropriate levels of cover	SRU HPB, UGI, Vascular (ALL) Urology (elective & emergency) Colorectal (unscheduled only)	ELECTIVE (day case) General Surgery & Urology

2.11 Benefits Criteria

The benefits criteria adopted for the purpose of the options appraisal reflected the priorities which emerged from a number of stakeholder engagement events at the outset of the Shaping Surgical Service programme. As these priorities were also reflective of the dimensions of quality and quality ambitions set out in the Scottish Government's [99]Quality Strategy, 2010 it was considered appropriate to use these as the benefits criteria for the options appraisal. The benefits criteria are outlined in the table below:

Criteria
Optimised Unscheduled Model ***Achieve optimum balance between emergency, urgent and elective care to maintain effective patient flow***
Optimised Use of Accommodation & Footprint across NHS Tayside ***Make the best use of resources at all three sites***
Optimise Patient Pathways ***Provide best opportunities to ensure anticipatory care planning***
Optimum Balance of Regional / Tertiary / Local Services ***Deliver sustainable, safe & high quality multiple site working***
Generating closer links & collaborative working with Primary Care ***Working together to provide a co-ordinated and complimentary approach to delivering end to end pathways for patients***
Potential for building a sustainable workforce providing continued development, education & training opportunities

[99] www.gov.scot/Resource/Doc/311667/0098354.pdf

Build capacity & capability to achieve sustainable change by attracting & retaining our workforce
Providing opportunities for making IT & eHealth Work Better for Patients & Staff ***Identifying opportunities for improvement & joined up working***

2.12 Weighting Criteria

A facilitated workshop was undertaken to agree the weighting of each of the benefits criteria. The options appraisal exercise undertaken aimed to ascertain the non-financial benefits of the short list of options. This involved assigning a weighting score to each criterion to reflect their relative importance and enable the allocation of scores to each of the service options. The following table highlights the weighting and rank for each of the benefits criteria.

Criteria	Weighting
Optimised Unscheduled Model **Achieve optimum balance between emergency, urgent and elective care to maintain effective patient flow**	**20**
Optimised Use of Accommodation & Footprint across NHS Tayside **Make the best use of resources at all three sites**	**20**
Optimise Patient Pathways **Provide best opportunities to ensure anticipatory care planning**	**14**
Optimum Balance of Regional / Tertiary / Local Services **Deliver sustainable, safe & high quality multiple site working**	**14**
Generating closer links & collaborative working with Primary Care **Working together to provide a co-ordinated and complimentary approach to delivering end to end pathways for patients**	**14**
Potential for building a sustainable workforce providing continued development, education & training opportunities **Build capacity and capability to achieve sustainable change by attracting & retaining our workforce**	**9**
Providing opportunities for making IT & eHealth Work Better for Patients & Staff **Identifying opportunities for improvement & joined up working**	**9**
Total	100

2.13 The Options Appraisal

A facilitated options appraisal event was delivered with a video conferencing link across the three hospital sites – NWH, PRI and SRTC. The event was attended by a wide range of participants from across NHS Tayside.

The workshop was facilitated by an internal advisor who had no declaration of interest in the outcome of the appraisal but was able to guide the participants through the process to ensure that it was conducted in line with the Scottish Capital Investment Manual (SCIM) Option Appraisal Guide[100].

All attendees were provided with the opportunity to attend an 'Engage and inform' session, which provided the opportunity to discuss each of the options in detail in addition to the options appraisal process. The challenges of involving patients, carers and the public in the more technical aspects of option appraisal have been highlighted in a number of cases by

[100] www.**scim**.scot.nhs.uk/Support/OA_**Guide**.htm

the Scottish Health Council (SHC). In view of this a specific facilitated workshop was provided for NHS Tayside Public Partners participating in the event to prepare and support participants to contribute effectively to the event.

2.14 Scoring of the Options

Using the agreed benefits criteria and weightings, participants were asked to score each of the options against the criteria. The scoring method adopted was to give each option a score of 0-3 against each benefits criterion. This was subsequently multiplied by the weighting to give each option a total score.

2.15 Summary of Ranking and Weighting

In summary the options appraisal workshop involved a number of engage and inform sessions to prepare participants for the event, and the subsequent event was independently facilitated and structured into two main sections:-

- Discussion of appraisal process and methodology,
- Scoring of each site option.

Throughout the session there was effective link up to all three hospital sites. Each site was monitored with regard to their progress and any issues which arose were dealt with by the facilitator. The facilitator assisted with discussion and provided independent advice on the appraisal process.

The results from the scoring are outlined in the table below. In terms of overall scoring option A and option D were identified as the preferred options. Further analysis highlighted that Option A, which is a single site acute surgical receiving model with optimisation of major, moderate and minor elective surgery was favoured for the highest weighted criteria 'Optimising the unscheduled model'. Option D however is a 24/7 acute surgical receiving unit on both the NWH and PRI sites and was favoured for the criteria "*Generating closer links & collaborative working with Primary Care*". This criterion was weighted as second in the weighted criteria. There was very little difference between these two options with respect to all other weighted criteria.

Rank	Option	Final Overall Weighted Score	Sum without weighting	Overall percentage of score (%)
2	**Option A**	**8978**	**611**	**26**
5	**Option B**	**3593**	**249**	**10**
4	**Option C**	**6115**	**421**	**18**
1	**Option D**	**8916**	**612**	**26**
3	**Option E**	**6953**	**469**	**20**

The agreed process with stakeholders following the options appraisal was to undertake a feasibility and financial evaluation of Option A and Option D, to ensure NHS Tayside investment objectives were assessed with the aim of presenting NHS Tayside Board with a recommendation on a single option, progressing to a full public consultation on the recommended option.

This business case thus provides the financial and feasibility assessment relating to the implementation of the two options. The two options are summarised below:

Option 1	**What does this Mean?**
PRI Elective general surgery, and urology (including major surgery) and some low risk vascular surgery will be delivered here. There will not be a facility for unscheduled admissions for surgery There will be cover for unscheduled inpatients overnight **Ninewells** All unscheduled admissions in Tayside will come here 24/7 Elective General Surgery, Urology, Vascular, Upper GI (including major surgery will be delivered here) **Stracathro** Day case and minor elective surgery will be delivered here. We will increase the number of cases we do here for patients who are fit to attend here	• If you need unscheduled surgery you will go to NWH • If you are fit and meet the criteria you may have minor elective procedures at SRTC • You may have major planned surgery at PRI or NWH

Option 2	**What does this Mean?**
PRI Elective general surgery and urology (including major surgery) will be delivered here Unplanned admissions and unscheduled surgical admissions may come here 24/7 There will be cover for unscheduled inpatient care overnight **Ninewells** Unplanned admissions and unscheduled admissions will come here 24/7 Elective general surgery, urology and vascular surgery (including major surgery) will be provided here **Stracathro** Day case and minor elective surgery will be delivered here We will increase the number of cases we do here for patients who are fit to attend	• If you need unscheduled surgery you will go to Ninewells or PRI • If you are fit and meet the criteria you may have minor elective procedures at Stracathro • You may have major surgery at PRI or Ninewells

The following PART 3 of this OBC will therefore assess the proposed service configuration for the TWO options indicating the benefits and risk of each from a financial, workforce and quality aspect. It will propose a single option that Tayside NHS Board will be asked to approve.

Part 3

Change Proposal & Recommendation

The purpose of this section is to provide a full description of the two options following the options appraisal which scored the highest. Both options are capable of achieving the benefits criteria however the affordability and viability test was not conducted at options appraisals stage as this was focussed upon the non financial benefits. It should be noted that Option 1, which is a single site acute surgical receiving model with optimisation of major, moderate and minor elective surgery was favoured for the highest weighted criteria, optimising the unscheduled model whereas option 2 was favoured for generating closer links and collaboration with primary care. Both these were tested with detailed clinical engagement after identifying the specialty most likely to be affected and challenges for each option are explored and discussed below along with financial appraisal.

Option 1 - Centralisation of Acute Surgical Site Receiving for all Unscheduled Surgery at Ninewells Hospital

3.0 **Option Overview- Option 1**

This option will see the transfer of ALL unscheduled surgical patient admissions from PRI to NWH (1719 patients per annum). Patients who have minor injuries presenting at A&E are not in scope and so are not affected.

The aim of this model will be to provide a total journey pathway for unscheduled surgical patients at NWH hospital only with the required access to dedicated Acute Surgical Receiving Unit (ASRU) and CEPOD theatres and associated infrastructure i.e. interventional radiology, dedicated critical care facilities required for safe effective unscheduled care delivery

The volume of change required affects 1% of total population (148,880 Perth and Kinross residents) and makes up 2.2% of the total unscheduled inpatient general surgical demand for the whole of NHS Tayside.

Option 1
Requires transfer 1719 unscheduled care admissions from PRI to Ninewells Hospital.
Only 420 (30%) of these cases convert to a surgical procedure which is equivalent to 1.3 patients per day requiring unscheduled surgery at PRI will transfer to Ninewells

How are we going to achieve this?

To enact Option 1 effectively NHS Tayside will need to provide 18 “beds” capacity on the Ninewells site to deliver these changes. As part of delivering this option the ASRU will require to be remodelled at Ninewells to meet this additional demand and some elective capacity will relocate to PRI to meet this change in demand.

The image below shows the balance of elective and unscheduled demand (general surgical and urology admissions) under option 1.

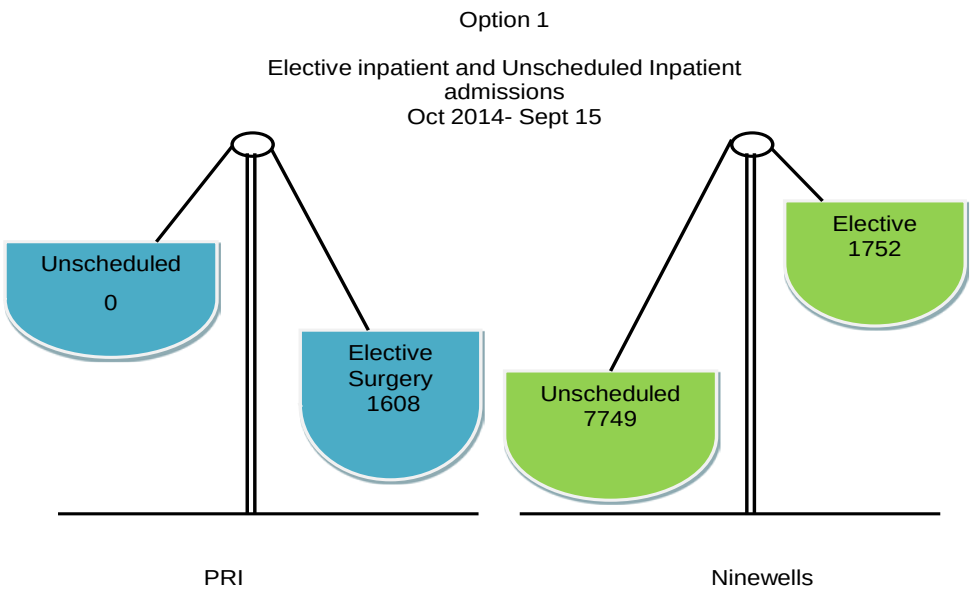
Note: The figures below only include and refer to General Surgery and Urology, October 2014 – September 2015

PRI Scales

- Emergency: 0 – This reflects all the emergency admissions being transferred to Ninewells.
- Elective: 1,608 – This includes current elective admissions to Ninewells plus the estimated additional 600 elective admissions to PRI as a result of shifting all emergency admissions to Ninewells. Please note, the figure of 600 was arrived at using standard capacity planning methodology.

Ninewells Scales

- Emergency: 7,749 – this is the number of emergency admissions to Ninewells, if all PRI emergency activity is transferred to Ninewells.
- Elective: 1,752 – this is the current number of elective admissions to Ninewells minus the 600 elective admissions which could be transferred to PRI due to the transfer of emergency admissions to Ninewells.



The image shows the potential shift in elective capacity from NWH to PRI is 600 and the relative increase in unscheduled capacity to Ninewells is 7,749 (transfer of 1,719 patients from PRI to NWH). Currently there are 1008 elective inpatient admissions to PRI which could be increased in this model by as much as 65-70% by separating elective and unscheduled care offering more elective care to the local population. This supports the organisation's ability to deliver safe effective unscheduled care whilst minimising the impact on our ability to

deliver timely elective care with minimal cancellation of elective surgery due to competing demand for unscheduled care.

3.1 Implications of Option 1

Unscheduled Care

The current operating model for Acute Surgical Receiving Unit (ASRU) in NWH will require a minimal increase in the number of the assessment trolleys (6) into Ward 8 to account for the increase in activity. Not all patients require surgical assessment will be admitted; a proportion will be assessed, investigated and discharged. Currently 30% of patients do not require surgery. This model allows for the appropriate access and management of patients. The 18 bed requirement which would have been needed in the PRI model is proportionate to the model of care with respect to the system related delays described earlier in this paper. It is not anticipated that 18 beds are required.

To deliver a single site receiving model a tactical plan will be required to establish the following:

- Radiology to support timely management of investigation, treatment pathway and discharge.
- Capacity modelling for assessment and admission
- Workforce plan to establish the medical, nursing and Advanced Nurse Practitioner requirements
- Non medical prescriber capacity
- Equipment to support increased throughput across an expanded ASRU footprint i.e. cardiac monitor, bladder scanner, ECG machine.
- Implementation of IHO recommendations for CEPOD

Data analysis shows that of the 1719 patients only 30% required surgery which translates to an average weekly demand of 15 hours. Theatre capacity is currently under review though our IHO programme of work and in this model by relocating CEPOD capacity currently used at PRI for unscheduled care we can shift the capacity and associated resources to Ninewells. The relative benefit and efficiency will deliver the additional CEPOD theatre capacity and staffing required. The CEPOD theatre will need to be provided both in and out of hours to accommodate additional unscheduled demand.

The elective capacity at PRI will be increased by a minimum of 5 sessions per week (previous CEPOD session released by moving all General Surgery unscheduled activity). Further opportunity to fully optimise theatre utilisation will support a minimum of 600 more elective surgeries. This expansion of elective capacity at PRI means that more elective care will be delivered closer locally in Perth and Kinross whereas under the current state model of care patients will have to travel to NWH or SRTC.

To manage the increase in unscheduled care at NWH radiology will alter the balance of inpatient and outpatient slots between NWH and PRI to reflect the new position and thus strengthening the diagnostic capability in ASRU at NWH.

Assessment on current patient transport means that the Scottish Ambulance Service (SAS) will need to review current provision to ensure appropriate transport available for paramedic response/GP urgent ambulance transport and low priority transport. SAS have been involved in the development business case and following selection of an option will review their arrangements.

Elective Care

Under this option there is opportunity to provide major elective General Surgery and Urology on the PRI site within a dedicated elective care facility. This removes the competing demands inherent in mixing unscheduled and elective patient flows. This will increase overall the number of elective surgeries across NHS Tayside with the potential of removing temporary theatre capacity and/or preventing patients being treated out with NHS Tayside. To do this a range of scenarios have been modelled by the NHS Tayside Business Unit to identify both the elective case volume per year that could be delivered through the available theatres as well as identification of the bed base that would be required to accommodate the patient's hospital stay. It should be noted that this modelling is based on average theatre times per case and average length of stay. The various scenarios demonstrate the maximum number of cases that could be delivered is circa 600 per year. The bed requirement to support the varying scenarios ranges from a low of 5 beds to a high of 8 beds. The capacity for beds is available within the current Ward 1 footprint at PRI.

Workforce modelling will ensure clear pathways of care are in place in the event of post operative complication for patient following elective surgery.

This option supports the continued throughput of patients into the critical care unit at PRI and therefore strengthening these types of service on the PRI site. Current capacity for critical care suggests that these cases can be accommodated under current capacity and staffing models.

Workforce

Option 1 will require a review of current workforce model and consultant job planning. Consultant cover can be provided from the budgeted establishment. For doctors in training this option offers sustainable and resilient medical cover especially in the out-of-hours period by concentrating junior doctor and senior medical support on a single site.

Elective capacity at PRI will be delivered with existing surgical and anaesthetic workforce. There will be a change in theatre provision at PRI reducing the requirement for out of hours theatre staffing and concomitant resilience in theatre staffing as staff (including medical staff) will no longer being vulnerable to call out in the night and the unplanned next day reduction as a result of post on call rest requirements.

The workforce modelling and subsequent plan will include a whole team approach to the delivery of safe and effective care including Physician Associate (PA) and Advance Nurse Practitioner roles (ANP). There will be a need review operational impact upon pharmacy and AHP services.

This model is sustainable from a workforce perspective in terms of efficient and sustainable medical staff and ANP cover and compliant doctor in training rotas. It promotes the move to a two site elective operating model for major general surgery in PRI and NWH with an increased capacity in day surgery across both sites. Any transfer of a service requires consideration of workforce skill set and competencies to be developed through staff development prior to implementation of any option.

Patient Experience

Most unscheduled care admissions do not require immediate access to the operating theatre and therefore would not be clinically compromised if required to travel to NWH. There will be

permanent ambulance bypass in place for unscheduled surgery patients similar to the current state process for weekend unscheduled admissions at PRI. It is intended that patients will not routinely be repatriated back to Perth but have their full stay in NWH to ensure continuity of care. Consideration of the continuing care needs of the patient will be made at individual level especially where length of stay is prolonged or social care needs are complex.

The patient and carer experience is of paramount importance and cannot be discounted. However, the compromise of having patients travel to NWH is in favour of providing high quality dedicated ASRU with immediate access to theatre if clinically required, senior clinical expertise and access to specialist diagnostics and critical care support provides the outweighed benefit and value. Evidence has demonstrated that patient experience of care is improved when unscheduled care services are well coordinated and available at the point of need ([101]Royal College of Surgeons England, 2014). At the same time we will increase by 60% the number and type of elective cases that can be performed at PRI bringing elective care closer to people's homes.

[101] https://www.rcseng.ac.**uk**/news/**improving-emergency-surgery**

Key Messages Option 1

- This model will provide a total journey pathway for unscheduled surgical patients at NWH hospital only with the required access to dedicated Acute Surgical Receiving Unit (ASRU) and CEPOD theatres and associated infrastructure i.e. interventional radiology, multi surgical speciality dedicated critical care facilities required for safe effective unscheduled care delivery. This allows us to correct the imbalance in access for unscheduled care through centralisation of acute surgical receiving.

- 24/7 Single site ASRU and CEPOD theatre are already in place in NWH which could easily be augmented to support additional demand and person centred access to unscheduled care by reducing pre operative length of stay.

- Through the IHO work and SSS combined we can deliver the additional CEPOD theatre capacity and quality standards and increase utilisation of elective capacity across the entire site.

- PRI will increase elective surgical admissions capacity to circa 1700 cases annually within the 30 bedded dedicated elective care ward giving better local access to care and increased utilisation of theatres. This is achieved through IHO smoothing of elective cases to increase elective utilisation of beds and theatre capacity.

- Increase utilisation of theatres across NHS Tayside offers the opportunity to decommission the mobile theatres and maintain appropriate use of theatres through reducing overruns and delayed start times and having more dedicated CEPOD reducing the need for unscheduled cases to “cut into” elective lists.

- Pathways of care will be developed that support safe and effective care for head injury patients and elective patients requiring a return to theatre.

- Appropriate access to interventional radiology and a full range of diagnostics for unscheduled cases at NWH in the model currently not available for patients admitted to PRI.

- Urology and General Surgery will require theatre capacity to transfer from NWH to PRI to which will complement existing Urology and General Surgery services on PRI site and support delivery of TTG.

- This model is sustainable from a workforce perspective in terms of efficient and sustainable medical staff and ANP cover and compliant junior doctor rotas.

- Training coalescence on one site to enhance education, supervision and move to greater excellence in training.

- Any transfer of a service requires consideration of workforce skill set and competencies to be developed through staff development prior to implementation.

- Patient and carer experience will need to include options for transport to NWH and close working with Scottish Ambulance Services.

Option 2 – Full Acute Surgical Receiving on Ninewells and PRI site

3.2 Option Overview- Option 2

This option will involve the provision of an Acute Surgical Receiving model on the PRI site and continuation of the ASRU model at NWH Hospital. Patients who have day case surgery are not in scope and so are not affected.

The aim of this model will be to introduce a second ASRU in NHS Tayside in the PRI site giving a total journey pathway for unscheduled surgical patients at PRI and NWH hospital with the required access to dedicated CEPOD theatres.

Option 2
Requires transfer 420 unscheduled care admissions from NWH to PRI.
It requires all elective inpatient work currently carried out at PRI (1008) to be transferred to NWH or SRTC

The volume of change required equates to 0.5% of total population (148,880 Perth and Kinross residents) and makes up the 0.6% of the total unscheduled inpatient general surgery demand for the whole of NHS Tayside.

How are we going to achieve this?

To enact Option 2 effectively, NHS Tayside will need to provide an additional 22 unscheduled care beds and adjacent assessment area to meet the standards and the demand for unscheduled care. This could be provided in the existing Ward 1 footprint at PRI but will leave no capacity for inpatient elective care which will have to be provided elsewhere.

In option 2 all unscheduled surgical activity for Perth and Kinross (P&K) residents will be carried out 7 days a week with 24 hour access to CEPOD theatre capacity on the PRI site (1,719 admission plus 420 P&K residents who currently are admitted to NWH at the weekend who will moved back to PRI = 2139).

The following image shows the balance of elective and unscheduled demand (general surgical and urology admissions) under option 2. It shows the increase in potential unscheduled care surgical admissions in PRI and the relative reduction in elective inpatient surgical capacity on the PRI site as a result of implementing two ASRU models in NHS Tayside.

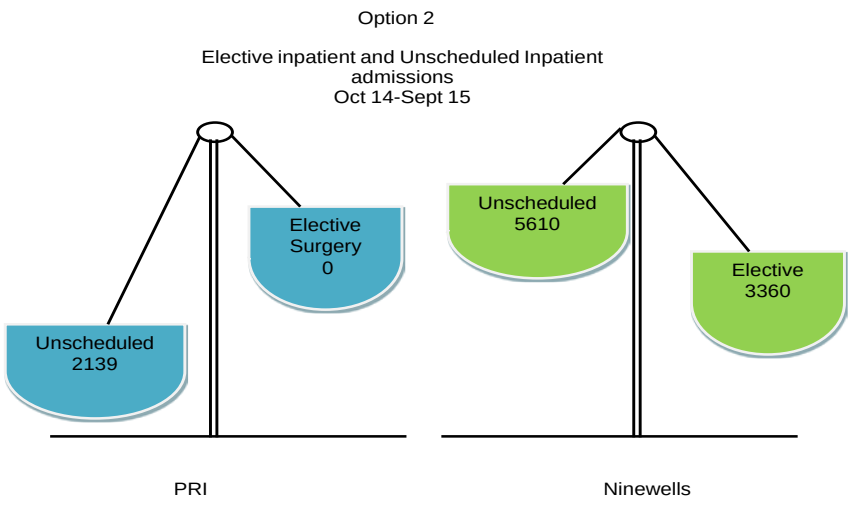
Note: The figures below only include and refer to General Surgery and Urology, October 2014 – September 2015

PRI Scales

- Emergency: 2,139 – this is the current number of PRI emergency admissions plus the 420 PH postcode admissions to Ninewells over the weekend. The figure of 420 was derived through postcode analysis and making a judgement on patients who would realistically be repatriated to PRI e.g. it is assumed that a patient with a PH postcode living in Invergowrie would still be admitted to Ninewells in an emergency.
- Elective: 0 – if PRI is equipped to provide a 24/7 service for emergency care, there will be no capacity to provide an elective service.

Ninewells Scales

- Emergency: 5,610 – this is the current Ninewells emergency admissions minus the 420 emergency PH postcode admissions repatriated to PRI.
- Elective: 3,360 – this is the current Ninewells elective admissions in addition to the elective admissions displaced from PRI.



3.3 Implications of Option 2

Unscheduled Care

Option 2 assumes the development of an ASRU created on the existing PRI Ward 1 footprint in addition to the ASRU on the NWH site (existing Ward 7). This gives a capacity of acute surgical receiving 22 beds plus 6 assessment trolleys in PRI and 24 beds plus 6 assessment trolleys in NWH.

Through this operating model it is expected that 100% of patients in PRI will have their total stay in this area i.e. admission, assessment, theatre and discharge as there is no opportunity for patient to step down to a specialty surgical ward on the PRI site. No capacity is available for elective care in this model unless additional facilities can be found on the PRI site and will need to be relocated elsewhere at NWH or SRTC.

The aim of this model will be to provide a total journey pathway for unscheduled surgical patients at PRI with the required access to dedicated unscheduled surgery theatres (CEPOD). All unscheduled care patients will be supported in this model which will need to include 24/7 access to theatre and critical care with immediate access to theatre if clinically required, senior clinical expertise and access to specialist diagnostics and critical care support.

This will require additional 5 CEPOD sessions per day to add to the current 5 available (total =10) and additional CEPOD capacity from 17.00 to 00.00 currently not available and continuation of overnight on call cover. The medical cover will be required and associated junior doctor cover to ensure compliant rotas and appropriate medical care available. This will need the additional recruitment of consultant and junior/middle grade doctors for PRI. The current infrastructure at PRI consists of 6 consultants doing a 1 in 6 on call cover with 1 middle grade and 1 foundation year doctor per shift. This will be increased and is not sustainable within current consultant numbers. To note for comparison NWH consultants currently operate a 1 in 9 on call rota.

As in option 1, capacity will be required for patients who need to return to theatre for complications of operations. The increase in unscheduled surgical numbers by 27% (420 patients repatriated from NWH) will require additional dedicated CEPOD capacity available 24/7. As all unscheduled surgery will be transferred to PRI this will require the separation of surgical and medical HDU capacity in PRI to deliver the capacity required.

The type and nature of unscheduled admissions undertaken at PRI will need clinical discussion. Currently some patient conditions already bypass PRI, for example Aortic Aneurysm; however there are a number of surgical procedures that cannot be delivered on the PRI site without investment e.g. interventional radiology, acute renal replacement therapy. The 420 unscheduled cases that currently go to NWH will be admitted and operated on in PRI.

The [102]Royal College of Surgeons (2014) advise that in order to deliver unscheduled surgery safely and effectively the full range of support services should be available. Currently on the PRI site there is no interventional radiology services, this requires to be established on the PRI site to ensure safe and effective care. Interventional radiology is a sub specialty of radiology providing minimally invasive image guided diagnosis and treatment. It is used widely in Vascular and Hepato-Billiary surgical intervention and a wide range of conditions require control of significant haemorrhage. Currently there are no plans to provide interventional radiology in PRI or capacity to provide this into the future and is a serious consideration when assessing this as a suitable option. There will be no change to the resources requirement to run the ASRU on the NWH Site in this model.

To deliver a 2 site acute receiving model the following as yet unsolved requirements will need to be addressed:

- Radiology to support timely management of investigation, treatment pathway and discharge including investment in additional interventional radiology services on the PRI site.
- Relocate elective care displaced by increased volume of unscheduled care to other NHS Tayside sites or build and staff an additional ward on the PRI site.
- Additional middle grade surgical staff in surgery and anaesthetics with cover of out of hours capacity and addresses the ongoing training experience issues in PRI
- Investment in additional pharmacy to cover ASRU model.

[102] https://www.rcseng.ac.**uk**/news/**improving-emergency-surgery**

- Procure equipment to support ASRU model i.e. cardiac monitor, bladder scanner, ECG machine, assessment trolleys/chairs.
- Employment of additional Advanced Nurse Practitioner roles to support 24/7 rotas.
- Senior consultant decision making presence 24/7 requiring an increase in consultant numbers.

Elective Surgery

Elective surgery cannot be supported on the PRI site in this option unless an additional ward is provided or there will be a need to move elective inpatient care to NWH or SRTC. The option to create another fully staffed ward on the PRI site is as yet untested or resourced. Perth patients will have to travel further than they currently do for some elective procedures. Capacity on the NWH site would require to be increased to accommodate the level of elective activity required.

Assessment on current ambulance transport means that SAS services will need to be re provided to ensure appropriate transport available for low acuity patient transport to support changes in elective flows.

Workforce

Consultant cover will be provided by existing consultant cohort but will need significant increase in middle grade and junior doctor to ensure 24/7medical cover. There will be a need to establish other workforce requirements to support this model such as new AHP roles and additional pharmacy support. This will include a review of new roles for example Physician Associate and ANP role onto the PRI site. This model will require a significant increase in junior doctor and registrar cover particularly in the out of hour's period and weekend which could be problematic given current recruitment challenges and rota compliance issues for doctor in training cover. At present cover is provide by a doctor in training and hospital at night in the out of hours periods and doctor in training at the weekend with consultant cover on an on call basis which is not adequate for 24/7 acute surgical receiving.

The nursing complement will require to be increased as there is a different workforce model for an ASRU. The changing profile of the patient group will require additional AHP and Pharmacy support to ensure adequate provision. Hospital at night capacity will need reviewing regarding requirement for the capacity to manage an additional 420 unscheduled admissions per annum repatriated from NWH to PRI and the associated patient acuity increase (in current model 420 PH postcode admissions go to Ninewells over the weekend).

To re-provide for unscheduled surgery patients at PRI there will need to be adequate provision of CEPOD theatre and anaesthetic cover. Theatre capacity is currently under review although there will need to be additional CEPOD operating hours (mandatory ring fenced theatre capacity designated by the recommendations of the [103]National Confidential Enquiry into Perioperative Deaths (2004). This will need to be provided both in and out of hours to accommodate additional unscheduled demand. The current provision on PRI site of CEPOD session is in hours only i.e. 13.00-17.30. Some operating does occur out or hours but at present is minimal (4 cases in a 12 week period with only 1 after 22.00 which was a non routine case).

Patient Experience

There is a growing appreciation from patients, staff and politicians that service needs to change with centralisation of services that will improve outcomes however we must also

[103] www.**ncepod**.org.uk

address concerns regarding patient transport and reshaping of service must be based on patient and staff benefit. Patients will be required to travel from Perth & Kinross to Dundee and Angus for in patient elective surgery.

[104] * In-patient care, Health Building Note 04-01: Adult in-patient facilities

Key Messages option 2

- Option 2 assumes the development of an ASRU on the existing Ward 1 footprint in PRI in addition to the ASRU on the Ninewells site. Through this operating model it is expected that 100% of patients will have their total stay in this area i.e. admission, assessment, theatre and discharge as there is no opportunity for patients to step down to a specialty surgical ward.

- Interventional radiology cannot be provided on the PRI site at present and it is not feasible to provide into the future.

- The elective capacity cannot be supported on the PRI site and will need to move to NWH or SRTC unless investment in facilities commensurate with current Health Facilities Scotland* regulation requirements and investment in additional staffing can be found on the PRI site.

- The type and nature of emergency admission will need clinical discussion. Currently some patient conditions already bypass PRI and will continue to do so. Some procedures also require assistance of other specialties i.e. Gynaecology and Vascular which will not be available on the PRI site.

- There will be no change to the resources requirement to run the ASRU on the Ninewells Site its current model however the IHO recommendation cannot be implanted in this model.

- CEPOD theatre capacity, doctors, theatre staff and anaesthetics will need to be provided at PRI both in and out of hours to accommodate additional emergency demand and be available 24/7. Some operating does occur out or hours but at present is minimal and not at weekend. The additional 5 CEPOD theatre capacity requires eliminates theatre capacity that can be used for elective surgery

- Any transfer of a service requires consideration of workforce skill set and competencies to be developed through staff development prior to implementation of any option

[105]*

[104] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/148502/HBN_04-01_Final.pdf.

[105] www.**sicsag**.scot.nhs.uk/.../2015-08-11-**SICSAG**-Annual-Report.pdf

3.4 Feasibility Assessment

The options appraisal highlighted the two preferred options. Further analysis of the options highlights that option 1, which is a single site ASRU with optimisation of major, moderate and minor elective surgery, was favoured for the highest weighted criteria 'Optimising the unscheduled model'. Option 2 sees a 24/7 ASRU on both the NWH and PRI sites and was favoured for the criteria "*Generating closer links & collaborative working with Primary Care*". This criterion was weighted as second in the weighted criteria. There was very little difference between these two options with respect to all other weighted criteria.

Please note both of these options assume optimisation of SRTC within the criteria for surgery at that site.

The table below summarises the feasibility and financial implications of each of these options against NHS Tayside current investment objectives as set out in the 5 Year Transformation programme.

NHS Tayside Investment Objectives: How will patients, staff and organisation benefit from each of the options:	**Option 1** Single ASRU offering safe and faster access to unscheduled care. Optimisation of major, moderate and minor elective surgery on PRI site. Equitable care and fits in with current management strategies of IHO.	**Option 2** Acute surgical receiving unit on both the NWH and PRI sites. Major and intermediate elective surgery delivered on NWH site only. The available level of care will still requires transfer of some patients to NWH and so does not provide the full answer- NWH will always manage the higher severity cases. This option has been tested twice before and failed with GP continued use of NWH.
Improving patient outcomes, quality and safety	Achieves this investment objective in full as a safe high quality unscheduled care model with no capital investment required. Provides a dedicated ASRU for all unscheduled surgical patients across Tayside. Provides a dynamic work environment for centres of excellence in Unscheduled and Elective Care on both hospital sites. Delivery of optimal training opportunities for junior doctors and compliance with rotas. Allows separating elective and unscheduled flow and delivery of	Partially achieves investment outcome due to infrastructure and footprint but with no confirmed capital plan for investment. Provides acute surgical receiving unit within a ward based area duplicating the model in NWH. Workforce retains level of skill across both Elective and Unscheduled Pathways of Care in both sites. Current issues and risks associated with medical workforce continue including rota compliance and delivery of standard medical training opportunities.

	IHO work. Supports compliant medical workforce rotas.	
Cost effective service delivery	Provides additional capacity for elective care through effective use of underutilised theatre capacity on PRI site. Provides sufficient capacity to meet demand for both elective and unscheduled surgical patients. Provides opportunity to reduce reliance on temporary theatre capacity.	Infrastructure costs will be required in terms of additional CEPOD theatre capacity to cover 24/7 period. No capacity to deliver any inpatient elective activity on site with current footprint. Some daycase will be able to be continued. Places high burden on NWH to increase elective activity if no additional ward capacity is available.
Patient Experience	Unscheduled care is provided in dedicated facility with staff skilled in unscheduled surgical care Patient experience is enhanced at PRI as there is ring fenced elective facility promoting enhanced recovery following major surgery with no competing demands from unscheduled acutely ill patients. More elective capacity will be provided in PRI for the local population.	A bigger proportion of Unscheduled care is provided locally but not all i.e. vascular. Patients will still have to travel to NWH or SRTC for major/intermediate elective surgery due to availability of radiology resources and associated clinical specialties support for some cases.
Achieving financial balance	Requires minimal revenue investment but not capital: overall potential to reduce operating cost through decommission of mobile theatre and reducing theatre and medical on call models. Some additional ANP posts required to cover 24/7 ASRU models. Changes in current consultant rotas to cover 24/7 ASRU single site to be agreed. Provides high quality safe unscheduled model, retains major elective surgery on both sites.	Requires capital and revenue investment: Additional fully staffed In Patient Ward which is not yet tested. Additional Theatre and staffing to create 24/7 CEPOD. Interventional radiology 24/7 on PRI site which is currently not feasible. Additional consultant surgeon and anaesthetic cover 24/7. Recruitment to new ANP post Changes to Hospital at Night team capacity as yet untested.

3.5 Informing, Engaging and Involving

The Shaping Surgical Service programme has its own dedicated Communication and Engagement Group and works to a communications and engagement plan.

Its aim is two fold

1. To set out the right communications materials and channels and engagement opportunities process and ongoing communications and engagement opportunities.
2. Ensure the options appraisal will be delivered in line with guidance set out by the National Health Service Reform (Scotland) Act (2004)[106].

There was a strong commitment from the outset of the programme to involving all Stakeholder Groups in defining the priorities for the SSS programme. The Programme Board undertook a Stakeholder mapping session to undertake stakeholder identification and analysis.

Throughout the initial engagement period, over 19 engagement events were delivered to ensure engagement and involvement in identifying the priorities for the programme. During Phase 2, operational and clinical leads continued to engage with their groups to ensure that transparency of conversations and discussions continued. The Programme Leadership team also continued to engage at local and national level with stakeholders regarding progress of the Programme. The views of stakeholders were included in the creation of the Programme priorities.

The Communications and Engagement Approach

There is an overarching programme of internal and external communications with high level messages agreed for 2020 Vision – Shaping Surgical Services for NHS Tayside. The following key messages are used to reinforce the purpose and aims of the overall programme in all staff and public communications.

- Place quality and safety at the forefront of all our surgical services.
- Improve patient care through comprehensive service planning, guided by our frontline clinicians, patients and carers.
- Achieve a balance between emergency, urgent and elective care to maintain effective patient flow.
- Improve integration and efficiency of surgical services.
- Foster the growth and development of all staff through seamless integration of our medical and nursing training programs into the surgical service.
- Commitment to surgical innovation and clinical research.
- Deliver all local and national targets meeting patient expectations.
- Be recognised as an exemplar provider of healthcare when compared to national peers.
- Better understand demand and capacity in order to deliver operational efficiency.

Listening to our key stakeholders has shaped this outline business case with some key learning as follows:

[106] www.parliament.scot/ResearchBriefingsAndF**acts**heets/.../SB_11-49.pdf.

Don't be frightened to have conversations about money – these are real discussions. However, the focus is on safety and quality and offering safe, effective, high-quality services to all our patients

The OOH group need to be part of consultation – previous engagement meeting with community council at Ballinluig

The worst thing that could happen to a patient is to be brought in by ambulance and then have to wait on corridor at A&E

Make this a positive conversation. It's not all about the closure of anything – it's the building of something great in Tayside which we should tell people about in a positive way. "What is being offered here in Tayside for patients comes with huge benefits in terms of specialist care when folk need it, and back closer to home when the acute episode is over." The best of both worlds

Travelling distances and transport are the major issues here – especially in remote and rural areas. Accessibility will be an issue so full consideration of solutions must happen and also look at benefits people are entitled to when they have to travel o hospital.

In the event of an unplanned admission, I would want to be cared for in the safest place with the most specialist staff for that field. "The public associates a specialist unit with the best care possible in the hands of experts."

The "Emergency" terminology should be changed and Unplanned admissions and procedures used instead, with a clear explanation of what "unplanned" actually means and, just as importantly, doesn't mean

Communication and engagement –next steps

The foundation of the next steps for communication and engagement will follow the well established principles of informing engaging and consulting people in service change. The plan to support this will include identification of the stakeholders who will have an interest or be affected by the proposals. This will include staff, clinicians, service managers, patients, public partners, communities and third sector organisations. Methods of engagement and communication channels will include a range of ways in which people can comment or share their thoughts and ideas. A consultation document will be developed to give background to the programme of work and to describe the process to reach the option/s which now falls for consultation. The document will include key points which require comment from all stakeholders.

To facilitate discussion and feedback, activities will be arranged to allow stakeholders to attend and be provided with more in depth information and the opportunity to share their views through discussion groups and other feedback mechanisms.

Equality & Diversity Impact Assessment (EQIA)

This section consider the impact of the proposed changes to key group and wider population

Following review of population demographics and health inequalities data there are a number of groups who may be affected by the proposed changes whose needs will have to be considered as follows:

Target Group	Impact	Rationale
Low income groups	Ability to afford increased travel costs out of local area	Low income groups and people in socioeconomic deprivation are more likely to require surgical intervention due to disease prevalent in socially deprived communities.
Older people	Ability to travel /opportunities for travel to areas out with locality	Older people are more likely to require surgical treatment due to the diseases prevalent in older age. More likely to be affected by changes in services due to being a potentially higher user.
Gypsy traveller communities	Engagement with healthcare services	Gypsy traveller community have difficulties engaging with health services due to accessibility and discrimination and are hard to reach for healthcare needs.

Polish communities	Engagement with healthcare services.	Polish communities engage with health services through different access routes i.e. via A&E and are less likely to visit a GP.
Disabled people	Ability to travel /opportunities for travel out of local area.	The ability to access accessible travel options for care out with the local area.
Black Minority and Asian (BMA) groups	Engagement with healthcare services and accessibility to healthcare.	Some diseases related to the in scope services are more prevalent in BMA communities i.e. bowel disease.
Staff groups (surgical nursing , medical , theatre and anaesthetics)	Changes to job role or job location.	Changes to job role or job location may impact on ability to maintain employment in NHS Tayside if suitable job alternatives are not available.

The intended target group(s) will include residents of Perth and Kinross who require access to healthcare services and specifically those groups who may be negatively affected by the changes. The proposed changes affect the population based in Dundee and Angus to a much lesser degree.

Other groups who may be affected unintentionally (positively or negatively) cover the wider population of NHS tayside in particular to:

1. Patients who will have to travel for treatment (both options) which include options for transport and ability to pay for transport and,
2. carers who will have to travel to visit or support a relative/looked after person (both options)

People who are excluded from the benefits/disbenefits of the proposal include children and young families whose services are not affected by this proposal.

On recommendation to approve a single option we will conduct a full EQIA alongside wider public consultation to establish anything currently unknown that may affect our recommendations and develop criteria to monitor impacts that may arise after the proposal is implemented.

3.6 Financial & Economic Impact

Financial & Economic Impact

The unprecedented financial challenges facing the National Health Service requires all services to consider approaches to ensuring best value for the financial resources allocated. This is more than increasing efficiency and productivity within services but requires senior

clinical and managerial engagement to establish how best care can be delivered to minimise variation, and assure high quality, person centred care. Better care does not always equate to increasing resources, conversely improving care has the potential to reduce costs through better patient outcomes and efficient use of resources.

The previous chapters have highlighted the quality, safety and clinical variation within our current services and provided an overview of the strengths and weaknesses associated with the current model of service, option 1 and option 2 models of service delivery. This section provides an overview of the high level financial implications inherent in each of the service delivery models.

Previous Board papers have highlighted that NHS Tayside has an operating service model that extends beyond its budgeted financial allocation in terms of site configuration, workforce, medicines, and operational costs. The information below provides an overview of the fiscal opportunities and challenges associated with each model.

Current state
Retaining the status quo will mean that the current costs potentially released by option 1 will remain in the system as IHO theatre redesign cannot be implemented in current state model.

Option 1
High level assessment is indicative of the opportunity for service efficiency and related cost reduction through implementation of this option. This option is imperative in the implementation of IHO CEPOD Theatre redesign presented in this paper.

The move to a single site receiving model will allow a reconfiguration of services which releases costs associated with the current deployment of mobile theatre units on the Ninewells site; use of the Independent Sector to meet Treatment Time Guarantees

Current costs in each of these areas are noted below by way of example for cost reduction opportunity:

Mobile Theatres	£745k per unit per annum
Independent Sector	£598k based on current TTG backlog (non-recurring only)
Theatre Agency Nursing & Bank Nurse	£471k – based on Apr-Jul for theatres

Taking the above into account, Option 1 offers an opportunity to significantly reduce the current cost base.

Option 2

Option 2 provides no opportunity to reduce current cost base. Under option 2, these costs would either remain, or be replaced by significant investment in required capacity to provide full acute receiving service in line with standards and elective capacity.

The Board should note that a detailed financial appraisal will be undertaken during the period of consultation which follows approval of the preferred option. This appraisal will build on the detailed service review already undertaken, and will include confirmation of workforce models, support services and any reconfiguration costs.

The recommend option will reflect a move to upper quartile performance in relation to the following key performance indicators:

- Average length of stay for both elective and unscheduled patients;
- Pre-Operative length of stay;
- Cancelled elective procedures;
- Treatment Time Guarantee breaches.
- Rota compliance

This is consistent with a number of current initiatives within the Transformation Programme, in particular the Realistic Medicine Work stream.

3.7 Risk Analysis

There are four key areas within NHS Tayside strategic risk profile that the SSS recommended option has the potential to significantly reduce the risk exposure rating. These are:

- HEAT Targets for patients requiring elective surgery
- Medical & Nursing Workforce
- Capacity and Flow
- Financial Performance

Programme Management Risk Assessment and Analysis

Risk analysis has three main uses:

- To deliver a robust financial and contractual structure for the project;
- To create a risk management process during procurement and execution of the contract; and
- To demonstrate value for money for the Board's financial commitments and estimate the project out-turn cost.

The methodology used to analyse the risks for the project are as follows:

- Define as project has developed;
- Record on Project Risk Register; and
- Control through defined mitigation strategies.

The main risks of the proposed project are described in the following table:-

Risk	Impact	Probability	Owner	Mitigation Plan
Political Objection	High	Medium	Chief Operating Officer	Major service Change Stencil informs appropriate consultation & engagement – 3 month consultation phase will be followed even if not considered major service change.
Public Objection	High	Medium	Chief Operating Officer	Public Partner engagement to gauge acceptance for options prior to consultation.

				3 month consultation phase will be followed even if not consider major service change.
Clinical Objection	High	Medium /High	Associate Medical Director Surgery	Series of clinical engagement events drop in sessions and meeting with specialty to groups to understand need and objections based on clinical evidence. Consensus may be difficult to achieve however we will continue to work with clinical leads to agree a way forward that meets clinical need and patient safety to establish compromise position.
Transfer Of Staff	Medium	Low	General Manager Surgery	Full staff side engagement throughout. Workforce plan to be agreed through Area partnership forum. Meeting with staff groups identified most at risk of change (Ward 1 PRI, ASRU Ninewells, Theatre staff PRI, Consultants for General surgery & urology).
Availability Of Facilities	High	Medium	General Manager Surgery	Initial assessment of requirement conducted. Capital investment may be required, full asset assessment will be completed on approval of preferred option. Phase implementation taking cognisance of adaptation to implementation based on facilities development.
Unexpected Demand	Medium	Low	General Manager Surgery	Demographic profile and bed modelling completed at outset of programme– some flexibility of demand is calculated in plan.

Programme Timetable 2014-2017

Milestone	**Complete Target Date**
Building the options	April 2014 to August 2014
Options Appraisal	26 June 2015

Approval from CEO & NHS Tayside Board to progress to data collection on preferred options & engagement period	July 2015- September 2015
Data collection & evidence base case for change	September 16 to December 2016
Stakeholder engagement on case for change	January to March 2016
Building the Outline Business Case	March – July 2016
Stakeholder engagement on options	**August- October 2016**
Submission of Outline Business Case to NHS Tayside Board	**26th October 2016**
Consultation & Engagement (3 months)	November 2016- January 2017 (indicative but will be 3 month as a minimum)
Submission of Full Business Case to NHS Tayside Board	**March 2017**
Notification of Decision	April 2017
Initiation of Project Implementation	TBC
Phase 1 Service Design Changes	TBC
Phase 2 Recruitment and Training / Development	TBC
Phase 3 Initiation of activity	**July 2017- October 2017**
Review of Performance (PPE)	November 2017

Timescales will be dependent on NHS Tayside board reaching a decision regarding preferred option and any subsequent approvals required from the Scottish Government. The programme timetable is based on a 3 month consultation period which is required if the programme outputs are considered to be Major Service Change and good practice under Informing, Engaging and Consulting People in Developing Health and Community Care Services. CEL 4 (2010), Scottish Government.

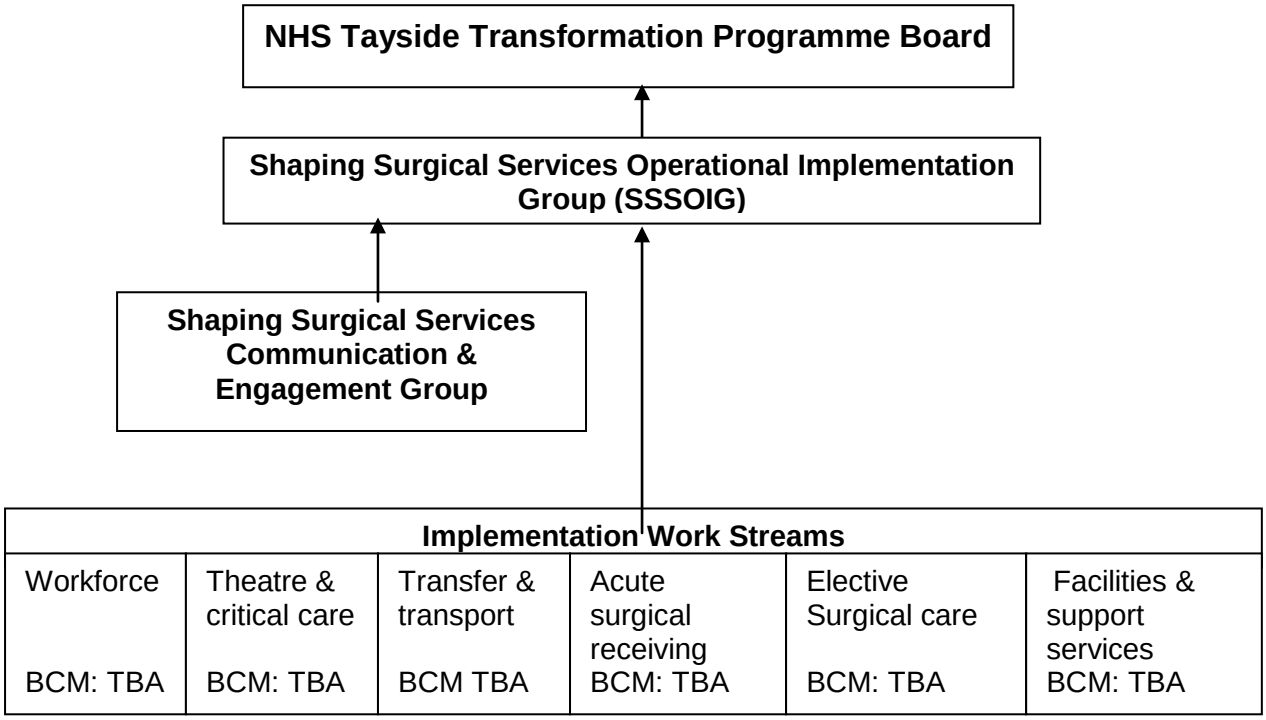
3.8 Management Case

This section considers the necessary partnership and managerial arrangements to successfully deliver the projects and achieve the anticipated benefits.

Project Management Arrangements

The following project management and governance arrangement as are in place:

Role	**Name**
Sponsor/Champion	Lorna Wiggin – Chief Operating Officer
Senior Responsible Officer (SRO)	Arlene Wood – General Manager Surgery
Overarching Clinical Lead	Professor Peter Stonebridge- Associate Medical Director Surgery
Programme Manager	Tracey Williams, Associate Director of Improvement
Improvement Advisor	TBA
Project Manager	TBA
Finance Lead (Revenue)	Stuart Lyall- Associate Director Finance
HR lead	Christopher Smith – Acting Associate Director Workforce
Communication & Engagement Lead	Margaret Dunning – Board Secretary & Chair of Communication & Engagement Group
Partnership Representative	Barbara Tucker (RCN) Allan Drummond (UNISON) Kate McDermott (staff side lead Transformation Programme)



The role and names may be amended as project requirements dictate. Business Change Managers (BCM) will be identified to lead each of the work streams. The role of the BCM is to provide operational expertise in their specific field of practice and provide operational leadership to support the implementation of each of the work stream. The work stream leads will be identified once the NHS Tayside Board agree the Outline Business Case (OBC) and identify a preferred option.

Project Controls

The work stream leads will report directly to the Shaping Surgical Services Operational Implementation Group (SSSOIG) with exception reports, change control notifications, risk and issue logs and requests for conflict resolution.

Project management arrangements will be funded through existing revenue and existing roles. Change Requests and identified Risks will be monitored and escalated, where appropriate, by the NHS Tayside Project Manager to the SSSOIG Group for endorsement and ongoing management.

Changes will be managed using the standard change management process. Once change is identified, the person requesting the change will complete a change request form. The following information is captured against each change:

- Unique sequential reference number
- Detailed description and reason for change
- Date raised and by whom
- Risk assessment
- Impact assessment
- Cost assessment
- Quantifiable cost saving / benefit of change
- Sign off at each stage, by NHS Tayside

Change requests will be reviewed frequently and escalated rapidly where necessary. All changes must be approved by the SSSOIG and a management summary detailing accumulative costs to date is included within the Project Managers update report for review. All change control forms are held within the project library for audit purposes.

Delivery Phase

The clinical reporting mechanism that we will use to track implementation and performance will be through our Shaping Surgical Services Operational Implementation Group (SSOIG).

This group serves nine main purposes:

- Support the Executive Lead, management team and front line staff in the implementation of Shaping Surgical Services Business Case.
- Develop and ratify the Operational Implementation Plan for Shaping Surgical Services.
- To act as clinical reference and managerial reference group for clinical issue and risk relating to implementation of Shaping Surgical Services Business case & outputs and interfaces with Institute for Healthcare Optimisation.
- To provide plan governance of risk and issues relating to implementation (non-clinical).
- To ensure implementation in partnership with staff side, public partners, clinical and professional groups.
- Facilitate the spread and sustainability of improvements within Shaping Surgical Services implementation plan.
- Track implementation of programme (sign off monthly reporting).
- Measure outputs according to planned benefits.
- Contribute to the delivery of NHS Tayside Clinical Strategy and Transformation Programme.

The mechanism will we use to feed back to Scottish Government and NHS Tayside Board will be through NHS Tayside Transformation programme board infrastructure with monthly reporting using NHS Tayside standard reporting template structure for the Transformation Programme.

Review Process

Post Project Evaluation (PPE)

NHS Tayside will carry out a Post Project Evaluation (PPE) of the project in line with Scottish Government Guidance. The process and development of the PPE will involve

all members of the project team. This work will incorporate development of questionnaires and surveys for completion by all stakeholder groups involved in this development.

The PPE is intended to provide tangible benefits and lessons learned in financial, operational and project management arrangements of future capital projects. On the project management side, the results of PPE will be used to improve the procedures related to the formulation, design/build, installation and commissioning of capital projects and on the financial side the results of the PPE will be used to improve the estimation costs for future projects, improve procurement procedures and assist in identifying and estimating cost efficiencies on existing projects.
The comprehensive PPE will involve an assessment of project issues related to the stages of the project life cycle and will look at assessing the Benefits Realisation criteria against the project outcomes plus it will look to analyse the project areas described previously. Through the use of PPE, it will then assist decision makers with evaluating the project after it has been completed, paying attention to the formation and implementation of the project as well as the continued performance of the project.

The PPE will assess the process issues, related to the formation and delivery of the project, as well as the outcome issues related to the achievement of the project objectives, the quality of the final product, the implementation costs and the ongoing operations.

The evaluation will examine whether:

- The strategic objectives set out in the Business Case were met
- The investment objectives identified in the Business Case were met
- The project outputs set in the Business Case were delivered
- An analysis of all cost development and final accounting
- Lessons were learned and how they have been recorded and disseminated across the organisation
- Major learning and development opportunities were provided by the project, and how has this learning been disseminated across the organisation
- The benefit realisation plan has been monitored and updated on a regular basis and have all benefits been realised or are some outcomes still to be achieved and how will this be done
- An assessment of the Project Team and Board structures demonstrated how these contributed or not to the overall project outcomes
- An analysis of specific issues that arose, post live service provision

The evaluation of the project will commence approximately three months after completion of the project. Any costs associated with carrying out the PPE will be absorbed by revenue funding.

3.9 Conclusion & recommendations

The changes proposed in this OBC case address the challenges faced in delivering high quality, safe and cost effective care in NHS Tayside. The case for change sets out those challenges in particular to workforce, resources and facilities available and the delivery of our Local Delivery Plan targets and legal obligations around Treatment Time Guarantees.

In acknowledgment of the above balance of benefits and costs the recommended option of the surgical and management team is Option 1.

Both options provide an opportunity to change the way services are delivered across NHS Tayside. Importantly both options require NHS Tayside to ensure utilisation of all 3 sites. However it is important to note that only option one will maintain and strengthen the surgical service at PRI by increasing major general surgery, utilising the inpatient bed and theatre capacity, freed up by having a single site ASRU.

This paper recommends the configuration of Surgical Services as outlined in Option 1 and that progress towards a 3-month public consultation is commenced with immediate effect.

Recommendations

1. Option 1 is approved as the preferred option as it is the most cost effective and clinically deliverable.
2. A full financial case and implementation plan is commenced for option 1
3. A workforce plan is developed for option 1 which is done in partnership with staff side and Area Partnership Forum.
4. A three month engagement period will commence from approval of this case to fully engage with the public which will run commensurate with the planning phase.
5. The engagement process will be supported and in collaboration by our health and social partnership who have access to local populations through local planning groups and Public Partners.
6. A full equality and diversity impact assessment will be completed for option one.
7. The SSOIG will be accountable for the delivery and implementation with overarching governance provide by the Transformation Programme Board.

NHS Tayside

NHS Tayside

2020 Vision

Shaping Surgical Services

Document Control Information -	
Control Status	*Working document*
Date Last Updated	*14th October 2016*
Version Number	*V7*
Author	*Tracey Williams*

Shaping Surgical Services Communications & Engagement Plan

NHS Tayside

Document History

Location:
This document will be located in the Shared Drive for Whole System Flow

Revision History:

This document has been revised as below

Revision Date	Previous Revision	Summary of Changes	Version
21 March 2016	Unknown	Amalgamation of the previous two plans to form the ongoing comms & engagement	V1/V2
22 April 2016	21/03/2016	Revision at Communication & engagement Group	V3
6 June 2016	22/04/2016	Update to engagement activities	V4
8 August 2016	06/06/2016	Update to engagement activities	V5
26 September 2016	08/08/2016	Update to engagement activities	V6
17 October 2016	26/09/2016	Revised programme timetable	V7

Distribution This document has been distributed to

Name	Title	Date of Issue	Version
Tracey Williams	Associate Director of Improvement	21 March 2016	V1
Arlene Wood	General Manager, Surgery	21 March 2016	V1
Lorna Wiggin	Chief Operating Officer	23 March 2016	V2
Margaret Dunning	Board secretary (Chair of Communication & Engagement Group	22 April 2016	V3
Lorna Wiggin	Chief Operating Officer	6 June 2016	V4
Evonne Summers	Scottish Government	7 June 2016	V4
Peter Stonebridge		26 September 2016	V5
Arlene Wood	General Manager, Surgery	26 September 2016	V5
Lorna Wiggin	Chief Operating Officer	19th October 2016	V6
Arlene Wood	General Manager, Surgery	19th October 2016	V6
Peter Stonebridge	Associate Medical Director- surgery	19th October 2016	V6
Alan Cook	Associate Medical Director	19th October 2016	V6
John Connell	For NHS Tayside Board	27th October 2016	V7

This plan supersedes & includes all previous versions of Shaping Surgical Services Communication and engagement plans

Background

NHS Tayside recognises that achieving real, sustainable, system-wide improvement relies on a systematic approach to improving patient care and experience through robust service planning and redesign that is led by frontline clinicians and the voice of patients and carers. This approach reflects the recommendations of recent NHS England reports; those of Francis, Keogh and most recently by the Berwick Report *A promise to learn – a commitment to act: Improving the Safety of Patients in England*.

The work of Shaping Surgical Services was undertaken in response to a number of national and local priorities and the requirement for high quality care with optimisation and effective use of resources. The work undertaken pays attention to defining how surgical specialities should be delivered across NHS Tayside in order to respond to the strategies and policies described below

- The Healthcare Quality Strategy for Scotland (2010)
- Everyone Matters: 2020 Workforce Vision
- NHS Tayside Corporate Objectives
- The Patient Rights (Treatment Time Guarantee) (Scotland) Regulations 2012
- Health and Social Care Integration
- Clinical Services Strategy CEL(4) Informing, engaging and consulting people in developing health and community care
- Scottish Patient Safety Programme
- NHS Tayside vision and values

The Shaping Surgical Services Programme commenced in January 2014 with an agreed scope for the programme: elective and emergency surgical services within General Surgery including Colorectal, Hepato-biliary and upper gastro intestinal surgery, Urology and Vascular Surgery provided across our three acute sites – Ninewells Hospital, Perth Royal Infirmary and Stracathro Regional Treatment Centre.

More specifically the element of the patient pathway under consideration is the in-patient peri-operative phase. Service provision within specialist services and paediatric surgery are not in scope nor is outpatient or diagnostic services.

Mission statement

“To provide a high quality, person-centred, safe and effective surgical service to our community”

Guiding principles

NHS Boards are required to involve people (health service users, patients, staff, members of the public, carers, volunteers, and the voluntary organisations) in Designing, developing and delivering the health care services they provide for them. Using Scottish Government Guidance Informing, Engaging And Consulting

People In Developing Health And Community Care Services CEL 4 (2010)

In accordance with equalities legislation, including the public sector duties (http://www.equalityhumanrights.com/advice-and-guidance/public-sector-duties/), NHS Tayside will

- Ensure that the informing, engaging, consulting process is fully accessible to all equality groups; and
- Ensure that any potentially adverse impact of the proposed service change on different equality groups has been taken account by undertaking an equality impact assessment

In accordance with the guidance regarding service change and development NHS Tayside will inform potentially affected people, staff and communities of their proposal and the timetable for:

- Involving them in the development and appraisal of options.
- Involving them in a (proportionate) consultation on the agreed options.
- Reaching a decision.

An *equality and diversity impact assessment will establish* potentially adverse impacts of the proposed service change. NHS tayside will provide evidence of the impact of this public involvement on the final agreed service development or change. A key consideration will be how changes may affect them for example the travel arrangements of patients, carers, visitors and staff. All impacts will be taken into account in the final proposal following a period of consulting and engaging.

Particular focus throughout the work of the commission has been given to the four guiding principles within Berwick's report given to clinicians, managers and staff which include:

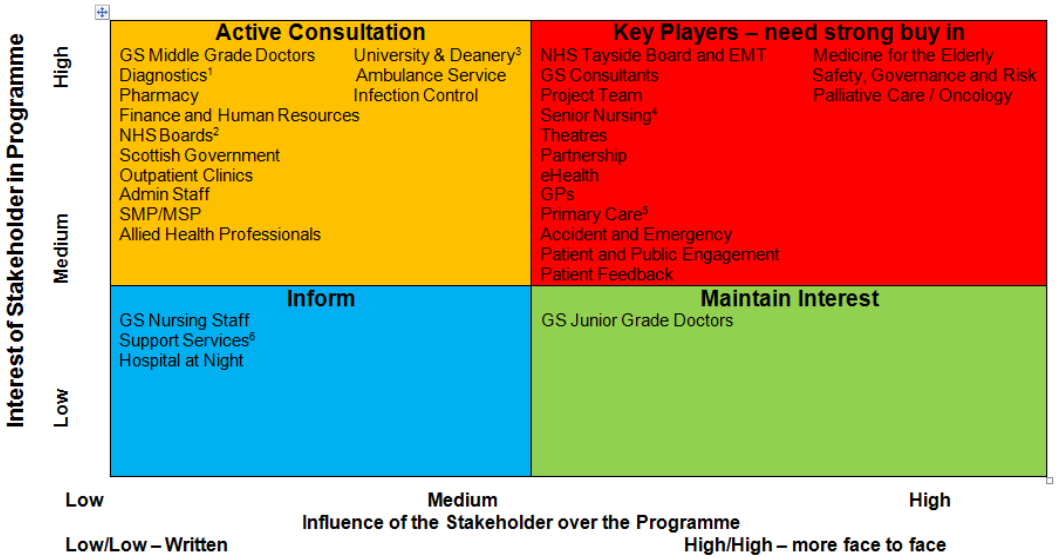
- Place the quality and safety of patient care above all other aims for NHS Tayside
- Engage, empower, and hear patients and carers throughout the entire system and at all times
- Foster wholeheartedly the growth and development of all staff with regard to their ability and opportunity to improve the processes within which they work
- Insist upon, and model in your own work thorough and unequivocal transparency, in the service of accountability, trust and the growth of knowledge

Aim of the communications and engagement plan

The aim of this communications and engagement plan for Shaping Surgical Services is to set out the right communications materials and channels and engagement opportunities process and ongoing communications and engagement opportunities.

There was a strong commitment from the outset of the programme to involving all Stakeholder Groups in defining the priorities for the SSS programme. The Programme Board undertook a Stakeholder mapping session to undertake

stakeholder identification and analysis.



Stakeholders

INTERNAL
Chief Executive
Chief Operating Officer
General Manager for Surgery
NHS Tayside Board
Strategic Management Team
Strategic Leadership Team
NHS Tayside Directors
Shaping Surgical Services Programme Board
Transformational Programme Board
Integrated Joint Board Health & Social Care
Surgical Directorate Staff
Specialist Surgery Directorate Staff
GS Consultants
GS SpRs
GS Junior Doctors
GS Nursing staff
GPs *(OOH, NHS 24, CHPs, community and GP stepdown beds)*
Theatres, Anaesthesia and Critical Care
Head of Nursing, Senior Charge Nurses, specialist nurses
MFE
Hospital at Night
AHPs
Diagnostics *(radiology, labs, endoscopy, pathology, vascular lab)*
Support Services *(medical records, SSD, Portering, Catering, Business Unit, Information Services, Blood transfusion)*
Pharmacy
Finance and Human Resources
NHS Boards (Fife / Grampian)

Outpatient Clinics eHealth Safety Governance and Risk Team Palliative Care / Oncology University Deanery (medical and nursing) Scottish Ambulance Service Area Partnership Forum representatives A&E Infection Control Acute Services Partnership Forum **EXTERNAL** Patients Families/Carers Public Media Scottish Government MSPs/MPs/local councillors Scottish Health Council Public Partners Third Sector

The Communications and Engagement Approach

There is an overarching programme of internal and external communications with high level messages agreed for 2020 Vision – Shaping Surgical Services for NHS Tayside. However, it is also important to develop a communications and engagement plan selecting the right communications channels, producing the right media to share more tailored messages to specific audiences and engaging with all stakeholders to ensure their participation at all stages. This will ensure the characteristics of the programme are clearly branded and understood.

Managers from Communications and Public Involvement will continue to forge strong links with the programme, supporting the development of communications and engagements plans, identifying key issues for internal and external communications and highlighting the impact of planned actions on stakeholders. Feedback will be encouraged in all communications with internal and external stakeholders and the range of ways in which groups and individuals can comment or share ideas will be overt in all communications and engagement. This communications and engagement plan underlines NHS Tayside's commitment to providing patients, their families, carers and staff with:

- regular, clear, easy-to-understand and consistent information
- openness and honesty in our communications both about what we can provide and, importantly, what we sometimes cannot provide and the reasons for this
- their right to participate in the designing of services
- the opportunity to feedback views and receive timely responses to any questions they may have
- an understanding that we know they have the insight, local knowledge and first-hand experiences to help us improve our services

Key messages

The following key messages are used to reinforce the purpose and aims of the overall programme in all staff and public-facing communications.

- Place quality and safety at the forefront of all our surgical services
- Improve patient care through comprehensive service planning, guided by our frontline clinicians, patients and carers
- Achieve a balance between emergency, urgent and elective care to maintain effective patient flow
- Improve integration and efficiency of surgical services
- Foster the growth and development of all staff through seamless integration of our medical and nursing training programs into the surgical service.
- Commitment to surgical innovation and clinical research.
- Deliver all local and national targets meeting patient expectations
- Be recognised as an exemplar provider of healthcare when compared to national peers
- Better understand demand and capacity in order to deliver operational efficiency

Progress so far:

Since the Shaping Surgical Services (SSS) Programme was established in the Programme has worked with patients and staff over an extensive engagement period to create a process for establishing a sustainable future service model. Throughout the initial engagement period, over 19 engagement events were delivered to ensure engagement and involvement in identifying the priorities for the programme. During Phase 2, operational and clinical leads continued to engage with their groups to ensure that transparency of conversations and discussions continued. The Programme Leadership team also continued to engage at local and national level with stakeholders regarding progress of the Programme. The views of stakeholders were included in the creation of the Programme priorities.

Option Appraisal Process

In order to arrive at decisions about service change, sound analysis is essential. The case for change will be underpinned by a recognised evaluation process – option appraisal. Option appraisal is a technique for setting objectives, creating and reviewing options and analysing their relative costs and benefits. The process has been triangulated with the *Green Book*, which remains an authoritative guide to the principles of appraisal and evaluation and the SCIM Business Case Guide and Informing, Engaging and Consulting People in Developing Health and Community Care Services CEL 4 (2010), Scottish Government

We used clinical engagement and subject matter expertise to agree a list of 18 potential options. These were reduced to a short list of 5 options by the, then SSS Programme Board with support from Steps to Better Healthcare Programme (now Transformation Programme). As per national guidance the short list of options must include a benchmark option. This should usually be the status quo or ‘do minimum’ option i.e. the option which represents the genuine minimum input necessary to

maintain services at, or as close as possible to, their current level.

All SSS Programme Board members and work stream members and public partners were invited to score the short list of 5 options.NHS Boards are required to follow guidance on how they should develop and appraise potential options for change and have used the process set out in the NHS Reform (Scotland) Act (2004) for this appraisal.

The challenges of involving patients, carers and the public in the more technical aspects of option appraisal have been highlighted in a number of cases by the Scottish Health Council (SHC). We involved public partners and the Scottish Health Council in our options appraisal process and have followed that up with a more detailed analysis of the outcome with Public Partners and an SHC representative on 20th May 2016.

Criteria	Weighting
Optimise Patient Pathways Provide best opportunities to ensure anticipatory care planning	***14***
Optimised Emergency Model Achieve optimum balance between emergency, urgent and elective care to maintain effective patient flow	***20***
Optimum Balance of Regional / Tertiary / Local Services Deliver sustainable, safe & high quality multiple site working	***14***
Optimised Use of Accommodation & Footprint Across NHS Tayside Make the best use of resources at all three sites	***20***
Potential for building a sustainable workforce providing continued development, education & training opportunities Build capacity and capability to achieve sustainable change by attracting & retaining our workforce	***9***
Generating closer links & collaborative working with Primary Care Working together to provide a co-ordinated and complimentary approach to delivering end to end pathways for patients	***14***
Providing opportunities for making IT & eHealth Work Better For Patients & Staff Identifying opportunities for improvement & joined up working	***9***
Total	***100***

Following the analysis of option appraisal no one option was ranked as preferred. Two options achieved the highest scoring level compared to all others with only 1 point between them. Two preferred options were identified as:

Option 1	What does this Mean?
PRI • Elective general surgery, and urology (including major surgery) and some low risk vascular surgery will be delivered here. • There will not be a facility for emergency admissions for surgery • There will be cover for inpatient emergencies overnight **Ninewells** • All unplanned admissions and emergencies in Tayside will come here 24/7 • Elective..... **Stracathro** • Day case and minor elective surgery will be delivered here We will increase the number of cases we do here for patients who are fit to attend here	• If you need emergency surgery you will go to Ninewells • If you are fit and meet the criteria you may have minor elective procedures at Stracathro You may have major surgery at PRI or Ninewells

Option 2	What does this Mean?
PRI • Elective general surgery and urology (including major surgery) will be delivered here • Emergency surgical admissions may come here 24/7 • There will be cover for inpatient emergencies overnight **Ninewells** • Unplanned admissions and emergencies in Tayside will come here 24/7 • Elective general surgery, urology and vascular surgery (including major surgery) will be provided **here** **Stracathro** • Day case and minor elective surgery will be delivered here • We will increase the number of cases we do here for patients who are fit to attend	• If you need emergency surgery you will go to Ninewells or PRI • If you are fit and meet the criteria you may have minor elective procedures at Stracathro • You may have major surgery at PRI or Ninewells

The options appraisal supports NHS Tayside's aim: To provide a high quality, person-centred, safe and effective surgical service to our community this will keep patient care and experience at the heart of service delivery, and meet the organisational vision that

"Everyone has the best care experience possible".

Governance & Programme Infrastructure

The Shaping Surgical Service programme has its own dedicated Communication and Engagement Group and works to a communications and engagement plan.

Its aim is two fold

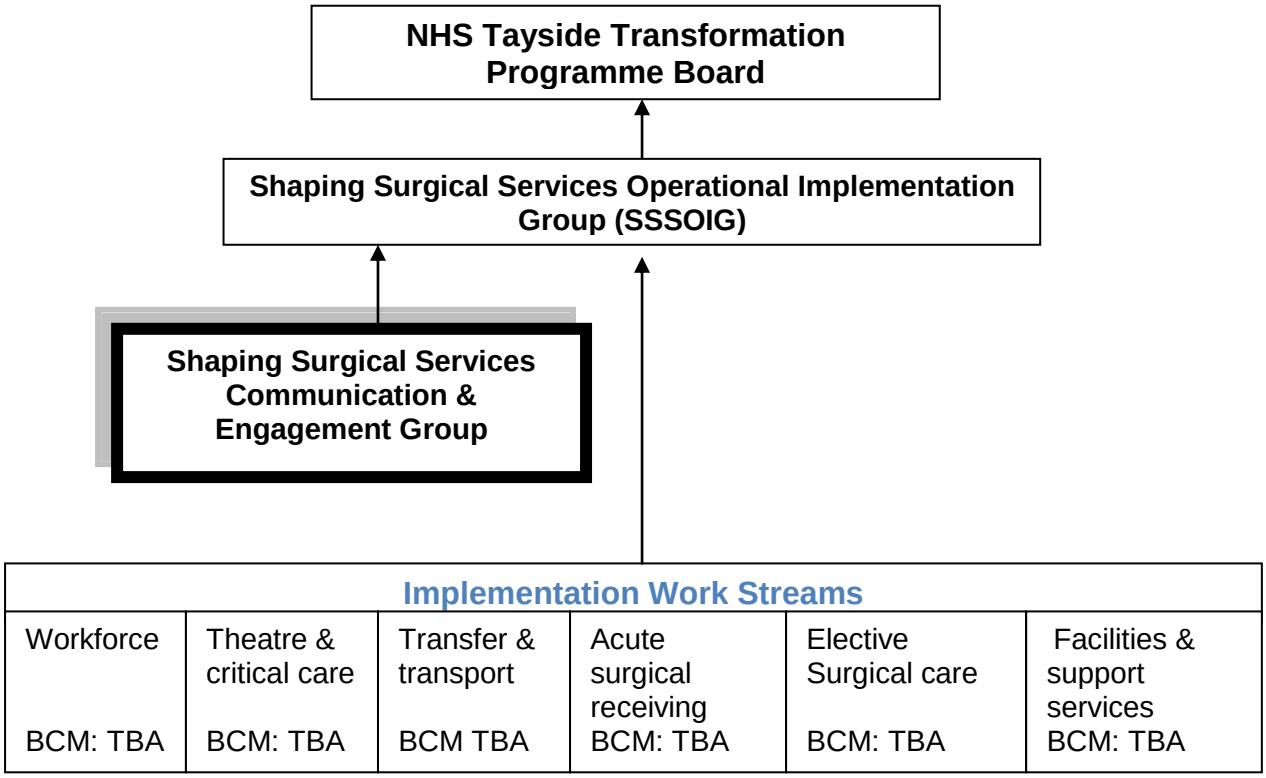
1. To set out the right communications materials and channels and engagement opportunities process and ongoing communications and engagement opportunities.

2. Ensure the options appraisal will be delivered in line with guidance set out by the National Health Service Reform (Scotland) Act (2004).

Programme Timetable 2014-2017

Milestone	**Complete Target Date**
Building the options	April 2014 to August 2014
Options Appraisal	26th June 2015
Approval from CEO & NHS Tayside Board to progress to data collection on preferred options & engagement period	July 2015- September 2015
Data collection & evidence base case for change	September 16 to December 2016
Stakeholder engagement on case for change	January to March 2016
Building the Outline Business Case	March – July 2016
Stakeholder engagement on options	**August- October 2016**
Submission of Outline Business Case to NHS Tayside Board	**26th October 2016**
Consultation & Engagement (3 months)	November 2016- January 2017 (indicative but will be 3 month as a minimum)
Submission of Full Business Case to NHS Tayside Board	**March 2017**
Notification of Decision	April 2017
Initiation of Project Implementation	TBC
Phase 1 Service Design Changes	TBC
Phase 2 Recruitment and Training / Development	TBC
Phase 3 Initiation of activity	**July 2017- October 2017**
Review of Performance (PPE)	November 2017

Project Management Arrangements



Communication & Engagement Group Membership

Role	Name	Abbr.
Chairperson	Margaret Dunning – Board Secretary	MD
Senior Responsible Officer (SRO)	Arlene Wood – General Manager Surgery	AW
Overarching Clinical Lead	Professor Peter Stonebridge- Associate Medical Director Surgery (from 1st August 2016) Replaces Mr Phillip McLoughlin	PS PMcL
Programme Manager	Tracey Williams, Associate Director of Improvement	TW
Equality & Diversity	Santosh Chima, Diversity & Inclusion Manager	SC
Informing, Engaging And Consulting People	Allyson Angus, Public Involvement Manager	AA
Scottish Health Council	Emma Ashman , Service Change Advisor	EA
Communication & Engagement Lead	Jane Duncan , Head of Communications	JD
Transformation programme	James Henderson , Transformation Programme Manager	JH
Partnership Representative	Barbara Tucker (RCN) Allan Drummond (UNISON) Kate McDermott (staff side lead Transformation Programme	BT AD KMc

2020 Vision - Shaping Surgical Services for NHS Tayside
Communications Plan and Timetable < 2016

Description of Activity	Lead	Objective	Timescale all exact times to be confirmed
Develop and agree key messages to ensure consistent approach to communications and engagement with all stakeholders.	**TCOE, Communications Department and project lead**	Key messages will be used throughout all channels of communications to ensure consistency	**Complete**
Develop one-page summary – Mission statement and aims	**NHS Tayside Corporate Communications Department**	To be used by leads/managers as briefing document and published on Homepage of Staffnet.	**Complete**
Develop comprehensive engagement event schedule	**TCOE, project members, Communications Department**		**Complete**
Staff survey developed. Core questions for wide dissemination.	**TCOE and project lead**	Online surveys -Surveymonkey to be designed and published.	**Complete www.surveymonkey.com/s/shapingsurgicalservices**
Feedback email address set up for all feedback/general comments to come in to.	**NHS Tayside Corporate Communications Department**	Dedicated email address to ensure everyone can comment/ask questions.	**Complete surgical services.tayside@nhs.net**
Dedicated Staffnet pages to be designed for one-stop-shop for all information relating to Shaping Surgical Services.	**NHS Tayside Corporate Communications Department/ TCOE.**	Staffnet	**Complete**
Core survey questions to be included in other NHS Tayside patient surveys.	**TCOE**	Online surveys, bedside surveys, paper surveys already being carried out or scheduled should	**Complete**

		include core questions.	
Credit-style cards with key messages designed and printed.	**NHS Tayside Corporate Communications Department and TCOE**	Message cards to hand out at engagement events/staff meetings and discussions.	**Complete**
Accompanying toolkit of materials for engagement events, static displays in canteens, etc. Branded Posters Flyers and Pop-ups developed with feedback email and staffnet pages advertised	**NHS Tayside Corporate Communications Department**	Posters Flyers Pop-ups	**Complete**
Core presentation developed to share key messages and ensure consistency of approach to gather feedback	**TCOE**	Powerpoint presentation	**Complete**
Letter from the Chief Executive to colleagues launching the engagement events and inviting participation	**Communications and Chief Executive**	Face-to-face meetings with opportunities to feedback online.	**Complete – letter issued week-commencing 17 March 2014**
General Vital Signs out to all NHST staff introducing the programme and informing about engagement events.	**NHS Tayside Corporate Communications Department**	Vital Signs, hard copy and online. Front page of Staffnet launch.	**To be issued 27 March 2014**
General awareness-raising and information-sharing and signposting to Staffnet page in Inbox weekly e-bulletin	**NHS Tayside Corporate Communications Department**		**To be issued 28 March 2014**
Engagement events with acute clinicians	**Project team and lead clinicians**	Face-to-face meetings with clinical teams	**Commencing Wednesday 16 April until Friday 9 May at venues across Tayside including PRI, Ninewells and Stracathro**
Engagement event with GPs	**Project team and lead clinicians**	Face-to-face meetings with GPs and opportunity to take part via video-conference	**Thursday 24 April, 7pm to 8pm.**
Specialty specific engagement events for	**Project team and lead clinicians**	Face-to-face meetings	**Tuesday 22 to Friday 25 April**

Colorectal, Upper GI / HPB, Urology, Vascular			
General engagement at Level 5 outside Doctors' Mess	**TCOE and comms team**	Face-to-face information-sharing and awareness-raising	**Noon to 2pm on Monday 14 April, Monday 19 May and Monday 26 May.**
Public engagement event with public partners	**Public Involvement Manager**	Face-to-face meeting with clinical team and public partners	**April 2014**
Public online survey available on YourNHSTayside website www.yournhstayside.scot.nhs.uk	**Public Involvement Manager/ TCOE**	Further opportunity for members of the public to take part and share their views	**April 2014**
Public engagement event at information stand on concourse, Level 7, Ninewells. High footfall area.	**Public Involvement Team, TCOE**	Further opportunity for members of the public to take part and share their views	**10 am to 4pm, Monday 21 April, Friday 25 April, Monday 5 May and Thursday 8 May.**
Other general engagement as necessary with public (depending on outcome of public partner event and what they advise on ongoing engagement)	**Public Involvement Manager and comms team**	Possible media releases, Facebook and Twitter postings	**Tbc - as and when necessary**
Shaping Surgical Services Launch Event	**All key stakeholders**	Pan-Tayside event with participation available via video-conferencing to share feedback and insights gathered from all engagement events and launching the Shaping Surgical Services programme	**Monday 26 May 5- 6.30pm.**
Information-sharing sessions to be held in three localities for clinicians and public partners	**Project lead, corporate communications and public involvement managers**	To inform all existing stakeholders and other interested parties about the Shaping Surgical Services story so far and prepare them for the next steps.	**By end of June 2015**
Develop briefing of the story so far – and what's next?	**NHS Tayside Corporate Communications**	To be used at workshops as a take-away briefing	**June 2015**

	Department and project lead	document, issued to Board members and directors and published on Homepage of Staffnet.	
Develop step-by-step guide and pack for options appraisal	**Communications Department and project lead**	To give stakeholders a comprehensive, easy-to-understand guide to the options appraisal process	**June 2015** SSS Site Option Appraisal FAQ.pub
Reactive media lines developed.	**NHS Tayside Corporate Communications Department**	To be used reactively at this stage ahead of Board reporting of option appraisal. Summary of the story so far, the objectives, the patient-centredness approach and the clinical leadership of the programme.	**June 2015**
Launch event for options appraisal with all stakeholders – with voting capability.	**Project lead and public involvement.**	To continue with inclusivity and wide-reaching nature of engagement of the programme so far.	**June 2015**
Accompanying toolkit of materials for engagement events including branded posters, flyers and pop-ups	**NHS Tayside Corporate Communications Department**	Reinforcing the SSS brand with clear messaging and visuals	**June 2015**
SSS newsletter issued with updates on the programme and informing about engagement events.	**Project lead, NHS Tayside Corporate Communications Department**	SSS newsletter launched as another branded regular communication for the programme	**June 2015**
SSS staffnet page to be kept up-to-date with all new materials	**Project lead, NHS Tayside Corporate Communications Department**	Reinforcing SSS Staffnet page as one-stop-shop for all updates and info	**June 2015**
Meetings with lead clinicians presenting more detailed options		To discuss the information being used in modelling both Options	**9 December 2015**
SSS newsletter issued with updates on the programme and informing about engagement events.	**Project lead, NHS Tayside Corporate Communications Department**	SSS newsletter launched as another branded regular communication for the programme	**December 2015**

2020 Vision - Shaping Surgical Services for NHS Tayside

Communications Plan and Timetable 2016 > 2017

Method of Engagement or Communication	Activity Description	Responsible Person	Timescales (planned)	Place & time of Activity	Distribution & Attendance	Stakeholder Involvement	Evaluation	How will we feedback?	Summary of progress & outcomes & Actions	Comments & supporting Documents
Letter	Request To share SHC view on the engagement to date in the service delivery model option appraisal.	AA	23rd March 2016	NA- letter NHS Tayside- Shaping Surgical Services Review- service delivery model option appraisal	Allyson Angus, Public Involvement Manager	NA	NA	Incorporate concerns into Business case process and Communication & engagement Plan	The Scottish Health Council sent a questionnaire to the seven Public Partners who had taken part in the option appraisal. We received five replies to the questionnaire.	SHC_engagement_A_letter-__NHST_S

Meeting	SSS Communication & Engagement Group	MD	9th Nov 2015 15th April 2016 16th May 2016 27th May 2016	Ninewells Hospital	C&E group Item 2 Action Note 09.11.15 C&E group Item 1 Agenda 15.04.16.doc Item 2 Action Note SSS C&E group 15.04 C& E group Item 1 Agenda 16.05.16.doc C&E group Agenda 27.05.16.doc Item 1 Agenda SSS C&E group 27.05.16.	Governance Communication & Engage-mint	NA	Na	Future meeting 2016 26 July 10 August, 7 September 5 October 9 November 21 December	
Face to Face Session	Open Face to Face Session for information & engagement with internal stakeholders	AW	31st March 2016	Perth Royal Infirmary, Steele Lecture Theatre 31 march 2016 5pm –	SSS - Engage Session Invites March	Participate by Attending Session	Survey monkey	Clinical meeting 25th May	Incorporate concerns and views of staff stakeholders	SSS_clinical_engagment_event_march SSS Engage & Infor Session March April

				7pm	SSS - Engagement Session Attendance F					
Face to Face Session	Open Face to Face Session for information & engagement with internal stakeholders	AW	April 6th 2016	Ninewells Hospital, Improvement Academy 06 April 2016 5pm-7pm	SSS - Engage Session Invites March SSS - Engagement Session Attendance M	Participate by Attending Session	Survey monkey	Clinical meeting 25th May	Incorporate concerns and views of staff stakeholders	SSS Engage & Infor Session March April SSS_clinical_engag ment_event_April
Face to Face Session	Open Face to Face Session for information & engagement with internal stakeholders	AW	April 7th 2016	Stracathro Hospital, Surgical meeting room 07 April 2016 5pm - 7pm	SSS - Engage Session Invites March	Participate by Attending Session	Survey monkey	Clinical meeting 25th May	Incorporate concerns and views of staff stakeholders	SSS Engage & Infor Session March April SSS_clinical_engag ment_event_07 Ap
Meeting	Briefing session	AA	22nd April 2016	Committee Room 1, Level 10, Ninewells	SHC Service Change Agenda 22 April 16.d	NA	NA	NA	Assurance for process of engagement	

Face to Face	Acute Services Partnership Forum	AW	5th May 2016	Seminar room C, level 7, Ninewells	Chair Lorna Wiggin, Director of Acute Services	Development session	NA	Na	Incorporate feedback Bring detailed workforce plan prior to next APF 27th July Request representative on SSSOIG	acute services partnership forum 5 M
Face to face	Chief Officers Group briefing	AW/TW	6th May 2016	Claverhouse , Dundee CHP meeting room 2 09.00-09.30	Lorna Wiggin , Director of Acute Services- IJB lead officers: David Lynch(Dundee) , Rob Packham (P&K) , Vicky Irons (Angus)	Meeting	NA	Email feedback chief officer response email	Contact key representatives regarding public consultation & Engagement Incorporate feedback in to business case	SSS_Chief_Officer pptx
Face to face session	Public Partners Engagement session	TW/ AA	20th May 2016	Improvement Academy , Ninewells Hospital 10.00-13.00	SSS PPG session briefing.docx SSS Progarmme STAFF Request for PI	Participate by Attending Session	PPG evaluation form	Share FAQ document	Develop FAQ document for consultation Incorporate concerns and views of patient partners Amend Outline	SSS_PPG event pptx.pptx Feedback from Shaping Surgical Se

									Business case to reflect suggestions from PPG	
Face to Face	Tayside Area Partnership forum	TW/AW	25th May 2016.	APF Committee APF Agenda 250516.doc		Briefing	NA	NA	Incorporate feedback Bring detailed workforce plan for Option to next APF 27th July	SSS_APF 250516 event pptx.pptx
Face to face session	Clinical speciality meeting (urology, colorectal, general surgery and OMFS)	PMcL	25th May 2016	Improvement Academy , Ninewells Hospital	Clinical consultants clinical enegagement session 25 may 2016.	Development session	NA	Further one to one /group meeting	Incorporate feedback into business case/ case for change Evidence base options	SSS_clinical engagement 25051
Face to face session	Senior charge nurse ward 7 Ninewells	TW	27th May 2016 11.00	Ward 7 , Ninewells	Colin Sayer – Field (SCN) & Ian Swan (ANP)	Meeting	NA	verbal	Incorporate feedback into business case	
Face to Face Session	Urology clinical meeting		30th May 2016	Seminar room C , Ninewells 1120-1200	Andrew Martindale, Paul Halliday, Slawomir Kata, Ghulam Nabi , Ghulam Nandwani, George	Meeting	NA	verbal	Incorporate feedback in to business case	Agenda urology meeting 300516.docx

					Nestoridis , Debi Das Chaudhury, Gillian Birrell Allison Robertson, and Catherine Paterson					
Face to face session	Briefing and engagement session Ward one staff PRI	AW	1st June 2016 14.30-15.30	Ward One PRI	Ward One staff, Kerry Wilson GM PRI, Arlene Wood GM Surgery, Lynn McAteer , Head of Nursing	Meeting	NA	verbal	Listen to staff concerns Incorporate feedback into business case	ward one invite session 1 june 201
Face to face	Briefing to Emergency Theatres User Group briefing	AW/TW	2nd June 2016	Anaesthetic Seminar Room, Level 6, Ninewells Hospital. 11am.	Anaesthetist, clinical lead Pam Johnstone and CSM theatres, Alastair Adam plus others	Meeting	NA	NA	Incorporate feedback in to business case	160602 Emergenc Theatre Users Grou
Face to Face	Briefing Clinical Director Medicine	TW	6TH June 2016	Improvement Academy breakout room 1	Elizabeth Henderson CSM surgery, James Cotton Clinical Director Medicine	Meeting	NA	Na	Incorporate feedback in to business case	
Face to face	Meeting Scottish Ambulance Service, East	TW	8th June 2016 At 10.00	76 West School Road, Dundee	Kenny Freeburn Head of Ambulance Services	meeting	NA	NA	Incorporate concerns and views into business	

	Central Division				Tayside				case	
Face to face	Staff side briefing	AW/TW	10th August 2016	Improvement Academy breakout room 2	Barbra Tucker	Review and draft of BC	NA	NA	Develop engagement process in partnership	
Face to face	Update to APF	AW/TW	21st September 2016 13.00 2016	Board Room Kings Cross	Area Partnership forum	Update	Feedback at next APF – November 23rd 2106	NA	Incorporate feedback into business case	Item 8 Update - Shaping Surgical Se
Face to face	Briefing re engagement process & events	AW/TW	22nd September 2016 14.00-16.00	Seminar room A , Improvement Academy r	Acute Partnership forum		Feedback at next APF – November 23rd 2106	NA	Incorporate feedback into business case	Item 8 Update - Shaping Surgical Se Acute Services Partnership Forum.ms
Face to face	Briefing to surgeon and surgical Advisory group (SAG)	PS	28th September 2016 16.30-18.00	Board Room Ninewells	Surgical Network Meeting	Seek view and opinions on preferred option.	On SAG agenda November post BC approval	NA	Incorporate feedback into business case Develop FAQ	SSS HB v5.ppt SSS Executive Summary v11.do

Face to face	Shaping Surgical Services Briefing NHS Tayside Transformation Programme Board	MD	28th September 2016 at 14.00	Committee Room 1, NW.	NHS Transformation Board Chairman John Connell	Briefing	NA	NA	Incorporate feedback into business case	SSS HB slides v2.p Shaping Surgical Services. transformat
Face to face	Briefing to senior leadership team and directors	PS/TW	3rd October 11.30-12.30 2016	Board room Ninewells	Senior Leadership Team	Briefing	NA	NA	Incorporate feedback into business case	SSS HB v5.ppt
Face to face	PRI clinical leads meeting-presentation on options	PS/AW/TW	7th October 14.00-16.00 2016	Steele lecture Theatre, PRI	PRI clinical leads	Briefing	NA	NA	Incorporate feedback into business case	SSS PRI v5.ppt
Face to face	All PRI staff event – presentation on options	PS	11th October, 12.30-14.00 2016	Steele lecture Theatre, PRI	All staff stakeholder PRI Supported by Kerry Wilson General Manager PRI and Jim Foulis , Associate Nurse Director PRI	Briefing	NA	NA	Incorporate feedback into business case	SSS PRI v5.ppt attendance list PR engagement 1110 Improving Surgica Services notes. PR

Face to face	Presentation on options	Alan Cook	20th October 2016 12.00 – 16.00	Improvement Academy Seminar room b	Area Clinical forum	Briefing	Briefing	NA	NA	SSS HB v6.ppt
Attendance at October 2016 NHS Tayside Board	Outline Business Case to NHS Tayside Board	AW/PS	October 26th 2016	Board room Ninewells	NHS Tayside Board	Board Decision	NA	Revision business case	Decision Making re Options for Implementation	NHS Board Cover Paper Shapig surgi Business case sss 191016 final .doc
Cont:										

Appendix – Long List of Options

Option	Narrative	PRI	Ninewells
1	All in Scope Services provided on PRI, Ninewells & Stracathro Sites	Surgical Receiving Unit & Elective Surgery (both) General Surgery, Vascular, Urology	Surgical Receiving Unit & Elective Surgery (both) General Surgery, Vascular, Urology
2	All in Scope Services provided on PRI & Ninewells sites with both day case & major elective provided in Stracathro site	Surgical Receiving Unit & Elective Surgery General Surgery, Vascular, Urology	Surgical Receiving Unit & Elective Surgery General Surgery, Vascular, Urology
3	All in Scope SRU Services provided on Ninewells Site with Elective (major) only on PRI and Elective (day case) only on Stracathro Site	Elective (major) General Surgery, Vascular, Urology	Surgical Receiving Unit General Surgery, Vascular, Urology
4	Colorectal Services provided on PRI Site with All in Scope SRU Services, UGI, HPB, ENDOCINE & Vascular Service & Urology on Ninewells with Elective (day case) only on Stracathro site	Colorectal Surgery	Surgical Receiving Unit UpperGI, Hepato-biliary, Endocrine, Vascular and Urology
5	All in Scope Elective (both) services on PRI site with All in scope SRU Services delivered on Ninewells site. Zero in scope services delivered on Stracathro site	Elective (both) General Surgery, Vascular, Urology	Surgical Receiving Unit General Surgery, Vascular, Urology
6	All in scope Elective (major) services delivered on PRI & Ninewells sites along with All in scope SRU services delivered on Ninewells site and all Elective (day case) services delivered on Stracathro site	Elective (major) General Surgery, Vascular, Urology	Surgical Receiving Unit General Surgery, Vascular, Urology Elective (major) General Surgery, Vascular, Urology
7	All in scope services delivered on Ninewells siteZero in scope Services delivered on either PRI or Stracathro sites	Nothing (no surgery services)	Surgical Receiving Unit ELECTIVE (both) General Surgery, Vascular, Urology
8	All in scope services delivered on PRI site Zero in scope Services delivered on either Ninewells or Stracathro sites	Surgical Receiving Unit & ELECTIVE (both) General Surgery, Vascular, Urology	Nothing (no surgery services)
9	All in scope services delivered on Stracathro siteZero in scope Services provided across PRI or Ninewells sites	Nothing (no surgery services)	Nothing (no surgery services)
10	All in Scope SRU Services provided on Ninewells & Stracathro sites with Elective (both) delivered on PRI site	Elective (both) General Surgery, Vascular, Urology	Surgical Receiving Unit General Surgery, Vascular, Urology
11	All in Scope SRU Services provided on PRI & Stracathro sites with Elective (both) delivered on Ninewells site	Surgical Receiving Unit General Surgery, Vascular, Urology	Elective (both) General Surgery, Vascular, Urology
12	All in Scope Elective (day case) delivered on PRI site, All in scope SRU services	Elective (day case) General Surgery, Vascular,	Surgical Receiving Unit General Surgery, Vascular,

	provided on Ninewells site with all in scope Elective (major) delivered on Stracathro site	Urology	Urology
13	Service Provision as delivered currently (STATUS QUO)	Surgical Receiving Elective (both) General Surgery, Vascular, Urology (Monday to Friday)	Surgical Receiving Unit General Surgery, Vascular, Urology ELECTIVE (both) General Surgery, Vascular, Urology
14	Service Provision as delivered currently, with SRU in PRI (day time only)	Surgical Receiving Unit (Day Time Only) General Surgery, Vascular, Urology ELECTIVE (both) General Surgery, Vascular, Urology (Monday to Friday)	Surgical Receiving Unit General Surgery, Vascular, Urology ELECTIVE (both) General Surgery, Vascular, Urology
15	All GS & Urology Elective (major / day case) services delivered on PRI, major elective in Ninewells with All in scope SRU services delivered on Ninewells site and GS& Urology (day case) services delivered on Stracathro site	ELECTIVE (both) General Surgery, Urology	SRU General Surgery, Vascular, Urology ELECTIVE (major) General Surgery, Vascular, Urology
16		Colorectal & Urology (Elective only), with appropriate levels of cover	Surgical Receiving Unit HPB, UGI, Vascular (ALL) Urology (elective & emergency) Colorectal (emergency only)
17	Increase elective surgery for all in scope services in PRI and increase day cases in PRI and SRTC, single site SRU in Ninewells with a decrease in elective / day case surgery in Ninewells	Increase elective surgery (inc. major), elective daycase	SRU Decrease elective / day case
18	Service Provision as delivered currently with SRU in PRI 24/7	Surgical Receiving UnitRU (24/7) General Surgery & Urology ELECTIVE (both) General Surgery &Urology	Surgical Receiving Unit General Surgery, Vascular, Urology ELECTIVE (both) General Surgery, Vascular, Urology

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item 7.2

BOARD107/2016
Tayside NHS Board
27 October 2016

WINTER PLANNING ARRANGEMENTS

1. PURPOSE OF THE REPORT

The purpose of this report is to present to NHS Tayside Board the Winter Planning arrangements and Unscheduled Care Improvement plan. This plan describes the collaborative approach to planning for "winter" by NHS Tayside and the Health and Social Care Partnerships of Angus, Dundee and Perth & Kinross". The plan forms our local Unscheduled Care Action Plan, is aligned to our Five Year Transformation Plan and is underpinned by the Six Essential Actions for Unscheduled Care. This plan has been written taking full account of the winter planning guidance 'The National Unscheduled Care Programme: Preparing for winter 2016/17' (DL (2016) 18) and the supporting 'Winter Preparedness: Self-assessment framework issued by the Scottish Government.

The Plan is a whole system health and social care response to ensure we meet the needs of our population and in particular the frail elderly and those who are acutely ill over the winter period. The plans will aim to build resilience through effective planning to meet the needs of our population and provide safe and effective care for people using our services by ensuring effective levels of capacity and resources are in place to meet expected activity levels.

The National Unscheduled Care Programme, uses the Six Essential Actions for Improving Unscheduled Care to inform its approach. The Six Essential Actions are:

- Clinically focused and empowered hospital management
- Hospital capacity and patient flow (emergency and elective) realignment
- Patient rather than bed management
- Medical and surgical processes arranged to improve patient flow through the unscheduled care pathway
- Seven day services appropriately targeted to reduce variation in weekend and out of hours working
- Ensuring patients are optimally cared for in their own homes or a homely setting.

2. RECOMMENDATIONS

The Board is asked to:

1. Endorse the winter plan for submission to Scottish Government
2. Note the improvement plans that underpins the winter plan
3. Note the resilience plans for winter preparedness in place

3. EXECUTIVE SUMMARY

The Winter Plan 2016/17 aims to support the best use of locally available resources as demand rises and /or capacity is limited in order to sustain safe, effective and person-centred care in line with our quality ambitions. It is recognised at both a local and national level that all year planning is required for unscheduled care. The Winter Plan is the escalation plan that enhances and supports the Board Local Unscheduled Care Improvement Plan. To further support the Winter Plan there is a system wide Escalation Plan and each Health & Social Care Partnership has their own detailed local plans. The escalation plans have agreed systems and process to respond to increased demand or capacity pressures with an escalation framework for health and social care with agreed actions and triggers.

In planning for Winter 2016/17 there is recognition of a number of key challenges and a focus on how these will be addressed:

- Elective Activity - the principle has been agreed that there should be no step down of elective activity thereafter proactive discharge management of is essential
- Noro Virus - the NHS Board has clear policies and procedures for the management of norovirus, including providing guidance to care homes to help keep patients in those homes should they acquire norovirus
- Capacity within acute services – an agreed whole system response to the findings from the Day of Care audits and delayed discharge plans is being agreed to ensure availability of bed for unscheduled care underpinned by a robust escalation response if required
- Staffing - staffing rotas will be in place by November 2016 this will include the management and professional support over weekends and public holidays.
- Additional services will be put in place by key support services like Pharmacy, Radiology, Facilities and Transport
- Immunisation - a robust programme of immunisation to address the flu virus has been established for both NHST staff and the public. Staff are being supported to access flu immunisation in order to protect patients, minimise staff's risk of exposure and reduce potential absence from work. The most vulnerable in the population i.e. children, people with underlying health conditions and the elderly have been invited to uptake immunisation in order to promote health and minimise the risk and impact that flu on these group
- Managing in severe weather - contingency plans are in place across all agencies should this situation arise, including access to suitable vehicles

The winter plan aims to minimise the potential disruption to services and improve outcomes for those who need to access services. This includes preventing delays in patients being discharged from hospital and preventing unnecessary admissions to hospital.

This paper provides an overview of the plan and associated improvement actions. The plan builds on learning from winter 2015/16 from what worked and what did not. This plan is built jointly partnership with all Health and Social Care Partnership and NHS Tayside

4. REPORT DETAIL

The aim of the Winter Plan 2016/17 is to assure individuals, the Integration Joint Boards and NHS Tayside Board have plans and systems in place to support the early intervention and action at points of pressure and to minimise the potential disruption to services, people who use our services and their carers.

The focus of the Plan is therefore to:

- Ensure that people get the right care, at the right time, in the right place, avoiding unnecessary admissions to hospital and ensuring that, once admitted, people are discharged as soon as they are ready, contributing to better health outcomes and making best use of resources

- Sustainable delivery of 98% four hour Emergency Access Standard

- Increase the percentage of people who are discharged within 72 hours of being ready and reduce the bed days associated with delays

- Deliver a balanced approach to the effective planning and scheduling of elective and unscheduled care

- Introduce forward planning to meet care requirements over the festive period for respiratory, circulatory and ICU pathways, 31 day and 62 day cancer waiting times including the use of anticipatory care planning

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

The plan is based on the 2020 Vision for Health and Social Care describes a health and social care system which is centred on:

- integrated health and social care services;
- a focus on prevention, anticipation and supported self-management;
- day case treatment as the norm where hospital treatment is required, and cannot be provided in a community setting;
- care being provided to the highest standards of quality and safety, with the person at the centre of all decisions;
- ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

This plan supports the NHS Tayside Local Delivery Plan, Five Year Transformation Plan and the Strategic Improvement Plans of the Health and Social Care Partnerships in Perth & Kinross, Dundee and Angus. Specific to this winter plan are the following standards:

- People diagnosed with cancer are treated within 31 days from decision to treat (95%) 62 days from urgent referral with suspicion of cancer (95%)
- 12 weeks Treatment Time Guarantee (TTG 100%) 18 weeks Referral to Treatment (RTT 90%) 12 weeks for first outpatient appointment (95% with stretch 100%)
- 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
- Zero delayed discharges over two weeks and working toward discharge from hospital within 72 hours of being ready for discharge

6. MEASURES FOR IMPROVEMENT

See full report for detailed measurement plan

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

There is a dedicated communication and engagement process which supports this plan. Stakeholders have been engaged in the development of this plan and include all Chief Officers of the Health and Social Care Partnerships, General Managers and clinicians. A winter planning

session was held on 21 September to support development of the plan document in partnership with clinicians and managers.

The session covered key issues such as

- Resilience
- Unscheduled / Elective care
- Seasonal Flu
- Respiratory Pathway
- Management information
- Out of Hours
- Governance
- Integration of Key Partners / Services

As in previous years, the Communications Team support the organisation's preparations for winter through the local and national winter campaigns.

NHS Tayside proactively links with the '*Be Healthwise This Winter'* campaign, tailoring the national key messages for the local situation and a local audience and releasing media releases and social media messages throughout the winter period.

The *Be Healthwise This Winter'* and Ready Scotland campaigns are featured on the NHST website using the digital assets provided by the national campaigns. We will also run a norovirus campaign with many messages featuring over the winter months.

Social media is the best channel for instant updates to information and will be used extensively, along with media releases, website updates, radio updates and sharing of messages with local partners for onward distribution.

The Corporate Communications Team updates the NHS Tayside website with weather and travel information as necessary and promotes Ready Scotland on the front page of its website.

The Communications Team will continue with regular press releases reminding people where to go seek appropriate support out of hours and over the holiday period. They will have a public communications strategy to raise awareness of access arrangements over the festive period, which includes an advertising campaign in local media with GP, pharmacy and MIIU opening hours. This is supported by regular social media and website posts to share information and signpost to available services.

The communications department has a proactive approach to ward closures to norovirus outbreaks and alerts all media outlets, updates social media and NHS Tayside website to every incident as soon as alert received from Infection Control Department. Clear key messages are deployed, including details of any visiting restrictions. NHS Tayside communications also actively promotes Norovirus publicity materials and national campaign assets and shares widely through social media channels, including Facebook and Twitter and local media.

NHS Tayside communications promotes our flu vaccination campaign to all NHS Tayside staff and volunteers, as well as members of the public in at-risk groups. Posters are produced for each area with details of local staff clinic sessions on NHS Tayside sites and key messages about protecting yourself and your family, your patients and the service. Information about public vaccination clinics in surgeries and pharmacies across Tayside are advertised in the local media and on social media. National campaign digital assets are also included on NHS Tayside's website and social media.

8. PATIENT EXPERIENCE

The plan takes a whole system health and social care response to support the best use of locally

available resources as demand rises and/or capacity is limited in order to sustain safe, effective and person-centred care.

9. RESOURCE IMPLICATIONS

As in previous years, Scottish Government has committed additional resource to all territorial Boards in supporting dedicated, multidisciplinary teams to improve patient flow. NHS Tayside's share of this resource is £540k.

The Health and Social Care Partnership has invested in additional capacity in the Health, Social Care and third sector workforce through Change Fund, Integrated Care Fund and latterly the Delayed Discharge funding streams to support both the unnecessary admission to hospital and prevention of discharge delay.

10. RISK ASSESSMENT

There are four key areas within NHS Tayside strategic risk profile that this plan has the potential to impact upon, these are:

- Access to unscheduled care service over the festive period
- 4 hours emergency access target
- Delayed Discharge target
- Capacity and Flow
- Financial Performance

11. LEGAL IMPLICATION

There are no known legal implications

12. INFORMATION TECHNOLOGY IMPLICATIONS

There are no known IT implications that are not already being addressed as part of NHS Tayside E-Health Plan

13. HEALTH & SAFETY IMPLICATIONS

There a no known Health and Safety Implications

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no healthcare associated infection implications

15. DELEGATION LEVEL

Chief Operating Officer
Chief Officers of Health & Social Care Partnership in Angus, Dundee and Perth & Kinross

16. TIMETABLE FOR IMPLEMENTATION

November 2016-March 2017

17. REPORT SIGN OFF

Ms L Wiggin	**Ms L McLay**
Chief Operating Officer	**Chief Executive**

Ms V Irons **Chief Officer** **Angus Health & Social Care Partnership**	**Mr D Lynch** **Chief Officer** **Dundee Health & Social Care Partnership**	**Mr R Packham** **Chief Officer** **Perth & Kinross Health & Social Care Partnership**

18. SUPPORTING DOCUMENTS

NHS Tayside Winter Plan
'The National Unscheduled Care Programme: Preparing for winter 2016/17' (DL (2016) 18)
'Winter Preparedness: Self-assessment framework issued by the Scottish Government.

The Scottish Government
Directorate for Health Performance & Delivery

Scottish Government
Riaghaltas na h-Alba
gov.scot

Dear Colleague

Preparing for Winter 2016/17

DL (2016) 18

12 August 2016

Addresses

To
1. Chief Executives
2. Winter Leads
3. Unscheduled Care Leads
4. IJB Chief Officers
5. Local Authority Chief Execs

Summary
This guidance will help to ensure that Health & Social Care services are well prepared for this winter. The national report 'Health & Social Care: Winter in Scotland in 2015/16' has been integrated into this year's guidance (Appendix 2). Winter plans should provide safe and effective care for people using services and should ensure effective levels of capacity and funding are in place to meet expected activity levels. This will support service delivery across the wider system of health and social care.

Background
The continuing focus on integration, improving delayed discharge and the six essential actions underpin the planning guidance for winter 2016/17. The guidance is also focused on planning for the additional pressures and business continuity challenges that are faced in winter.

Action
You are asked to lodge draft winter plan(s) on local winter planning arrangements with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements and should be published online. Plans / links to plan(s) should be sent to Winter_Planning_Team_Mailbox@gov.scot

Yours sincerely

JOHN CONNAGHAN CBE
NHSScotland Chief Operating Officer

GEOFF HUGGINS
Director for Health and Social Care Integration

Enquiries to:
Stuart Low
NHSScotland Resilience & Business Mgt Division

Tel: 0131 244 3458
E-mail:
stuart.low@gov.scot

Preparing for Winter 2016/17

1. Introduction

1.1 Planning for winter is a particularly important part of all-year-round planning and NHS Boards and their partners have already started to plan for this winter. The continuing focus on integration, improving delayed discharge and the six essential actions (Annex A) underpin the planning guidance for winter 2016/17 and will help to ensure that Health & Social Care Services are well prepared for this winter. The guidance is also focused on planning for the additional pressures and business continuity challenges that are faced in winter. Winter plans should provide safe and effective care for people using services and should ensure effective levels of capacity and funding are in place to meet expected activity levels. This will support service delivery across the whole system of health and social care.

1. 2 The Scottish Government has already had a high level of engagement with NHS Boards and Health and Social Care Partnerships around winter guidance for 2016/17. Earlier this year we supported NHS Boards and their partners to undertake a local review of service pressures and performance. In June we held an integration winter planning event for NHS Boards and Health & Social Care Partnerships to consider winter planning arrangements and priorities.

1.3 The national report 'Health & Social Care: Winter in Scotland in 2015/16' has been integrated into this year's guidance (Appendix 2).The official statistics show that Health & Social Care Services performed relatively well compared to the previous winter. In winter 2015/16 the NHS in Scotland increased capacity and carried out more activity with shorter lengths of stay. Scotland saw significant A&E waiting times performance improvements compared to previous winters with performance from October to March at 93.7%, the best winter performance since 2011/12. Delayed discharge performance improved, supporting improved flow through the system. The impact of influenza on GPs was low and below the levels expected in a normal influenza season. There were a significant number of influenza related cases who were admitted to hospital. The total number of patients with influenza managed in hospital or admitted to intensive care was greater than in recent seasons and comparable to last year. Statistics on levels of emergency admissions due to respiratory conditions were down on last year but above the recent average. NHS Boards also completed local reviews of pressures across their health and social care services which will help them to prepare for this winter.

1.4 Health and Social Care Partnerships play a crucial role in helping to ensure that people get the right care, at the right time, in the right place, avoiding unnecessary admissions to hospital and ensuring that, once admitted, people are discharged as soon as they are ready, contributing to better health outcomes and making best use of resources.

1.5 Unscheduled and elective care performance in Scotland compares favourably with other UK and international comparators. Robust planning and analysis should facilitate NHS Boards to pursue further sustainable improvement through 95% performance towards the 98% 4 hour Emergency Access Standard. This should also support the Treatment Time Guarantee (TTG) and ensure delayed discharges are kept to an absolute minimum. Health and Social Care Partnerships are expected to increase the percentage of people who are discharged within 72 hours of being ready and reduce the bed days associated with delays.

1.6 A balanced approach to the effective planning and scheduling of elective and unscheduled care will be needed. This will be particularly important in light of predicted emergency activity over the festive period, when any surge in respiratory and circulatory

admissions over the winter can increase pressures, particularly towards the end of December and into January and February. Support to understand the capacity and demand of each site is available through the Unscheduled Care 6 Essential Actions Improvement programme. Developing the Basic Buildings Blocks model (Essential Action 2) will provide a baseline of the whole system and enable robust planning. The focus of the Whole System Patient Flow Programme and Guided Patient Flow Assessment will also contribute to this overall picture.

1.7 Forward planning should ensure that cancer patients who have a MDT, diagnostic or treatment target date occurring over the festive period are not delayed and that 31 day and 62 day cancer waiting times are not adversely impacted. In addition, NHS Boards should work through Regional Planning Groups to ensure that both local and regional cancer treatment dates are maintained through the winter period.

1.8 Richard Foggo recently wrote to IJB Chief Officers and NHS Boards inviting them to submit an urgent care action plan for 2016-17. Boards will want to take account of the links between urgent care action plans and winter planning.

1.9 Changes in the cohorts of admitted patients and their care requirements over the festive period should be monitored. This will be particularly important within respiratory, circulatory and ICU pathways. Primary care and community services should be engaged in minimising transfers of care through use of anticipatory care planning. A directory of services and alternatives to admissions should be available, covering primary and community services and also third and independent sector social care provision. Any additional capacity in these areas should be highlighted.

1.10 Robust analysis should be undertaken to plan capacity and demand levels for this winter. Data available from ISD, via the Health and Social Care Data Integration and Intelligence Project (Source), can help with such analysis. Recent years activity levels and improvements in flow should be taken into account as part of this process. Trends over three to five years should be considered. We also expect winter plans to address variation in demand.

1.11 Plans must be explicit around the additional capacity planned for winter, including staffed medical and intermediate care beds, care packages, home/night sitting services accessible by GPs/NHS 24 and next day GP and hospital appointments. Deliverable plans for workforce capacity over the winter period must be agreed by October and detailed in the winter plan – these are important milestones. Nursing rotas that are made up for the festive period should not include the use of agency staff and should conform to workload planning tool guidance. It is important that this capacity is in place before the risk of boarding medical patients in surgical wards increases and that appropriate indicators of potential surge are monitored on a daily basis. Analysis should include triggers for whole system escalation processes to prevent access block.

1.12 Sustainably achieving safe and effective patient flow is critical to maintaining performance as a standard operating model across the winter period. Utilising the improved communication and leadership of the Capacity and Patient Flow Programme, including Safety Huddles, should focus on proactive discharge planning including, pre noon discharges, weekend discharges, utilisation of discharge lounge and criteria led discharge. A review of support services such as portering, cleaning, pharmacy and transport should be undertaken to ensure capacity is aligned to demand, not just within hours, but also across 7 days and out of hours periods.

1.13 The Chief Medical Officer strongly encourages all staff are vaccinated against seasonal flu, particularly front-line staff and those working in areas where patients might be at greater risk (paediatric, oncology, maternity, care of elderly, haematology, ICUs). The aim is to vaccinate 50% of front line staff and efforts should be made to make the vaccine available at times and places that are convenient for staff. Senior clinicians and NHS Managers should ensure staff understand the benefits of the vaccine to healthcare workers and to patients.

2. Critical Areas, Outcomes and Indicators

2.1 The critical areas identified below remain key to effective winter planning and should be the bedrock on which winter plans are built. The local indicators, which underpin each critical area, should be included in relevant local management processes to achieve the outcomes described. Indicators should also align with the unscheduled care 6 Essential Action Improvement Programme (summarised at Annex A). Winter plans should set out the geographies and frequency of the local indicators being monitored and provide further detail on how these indicators might be developed, where applicable.

1. Business continuity plans tested with partners. *(Appendix 1 - Checklist 1 refers)*
Outcome: • The board has fully tested business continuity management arrangements / plans in place to manage and mitigate against key disruptive risks including the impact of severe weather.
Local indicator(s): • progress against any actions from the testing of business continuity plans.

2. Escalation plans tested with partners. *(Appendix 1 - Checklist 2:1 refers)*
Outcome: • Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.
Local indicator(s): • attendance profile by day of week and time of day managed against available capacity • locally identified indicators of pressure (i.e.) % occupancy of ED, utilisation of trolley/cubicle, % of patients waiting for admission over 2, 4 hours • all indicators should be locally agreed and monitored.

3. **Safe & effective admission / discharge continues in the lead-up to and over the festive period and also in to January.** *(Appendix 1 - Checklist 2:2 and 2:4 refers)*
Outcomes: • Emergency and elective patients are safely and effectively admitted and discharged over the Christmas - New Year holiday period. • The numbers of patients receiving elective treatment reduces and the risk of boarding medical patients in surgical wards is minimised. • Patients do not have unnecessary stays in hospital; hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January.
Local indicator(s): • daily and cumulative balance of admissions / discharges over the festive period • levels of boarding medical patients in surgical wards • delayed discharge • community hospital bed occupancy • number of Social Work assessments including variances from planned levels.

4. **Strategies for additional surge capacity across Health & Social Care Services** *(Appendix 1 - Checklist 2:2 refers)*
Outcome: • The risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised. The staffing plans for additional surge capacity across health and social care services is agreed in October. The planned dates for the introduction of additional acute, community and social work capacity are agreed and that capacity is operational before the expected surge period. It is essential that additional capacity is developed alongside appropriate arrangements to create a safe and person centred environment.
Local indicator(s): • planned additional capacity and planned dates of introduction • planned number of additional staffed medical beds for winter by site and the planned date of introduction of these beds; • planned number of additional intermediate beds in the community and the planned date of introduction of these beds; • levels of boarding. • planned number of extra care packages • planned number of extra home night sitting services • planned number of extra next day GP and hospital appointments

5. **Whole system activity plans for winter: post-festive surge / respiratory pathway.** *(Appendix 1 - Checklists 2:2 and 6 refers)*
Outcome: • The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. Hospital models will include flows between front doors, receiving units, and downstream wards.
Local indicator(s): • daily number of cancelled elective procedures; • daily number of elective and emergency admissions and discharges; • number of respiratory admissions and variation from plan.

6. **Effective analysis to plan for and monitor winter capacity, activity, pressures and performance** *(Appendix 1 - Checklist 2:2 refers)*
Outcome: • NHS Boards have, and use, a range of analysis to effectively plan for and monitor winter capacity, activity, pressures and performance at board and site levels.
Local indicator(s) : • Agreed and resourced analytical plans for winter analysis.

7. **Workforce capacity plans & rotas for winter / festive period agreed by October.** *(Appendix 1 - Checklist 2:3 refers)*
Outcomes: • Rotas and workforce capacity plans for all disciplines are agreed for the winter (and particularly the 4 day festive holiday) period by October to underpin safe and effective admission and discharge of emergency and elective patients. This should encompass all relevant health and social care services. • Maintain discharges at normal levels over the two 4 day festive holiday periods
Local indicator(s): • workforce capacity plans & rotas for winter / festive period agreed by October; • effective local escalation of any deviation from plan and actions to address these; • extra capacity scheduled for the 'return to work' days after the four day festive break factored into annual leave management arrangements. • number of discharges on each of the 4 day festive holiday periods compared to number of normal daily discharges

8. **Discharges at weekends & bank holidays** *(Appendix 1 - Checklists 2:3 and 2:4 refers)*
Outcome: Patients are discharged at weekends and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital. Medical and Nurse Directors provide monthly report on weekend (pre-noon) discharge rate progress and performance.
Local indicator(s): • % of discharges that are criteria led on weekend and bank holidays; • daily number of elective and emergency admissions and discharges.

9. **The risk of patients being delayed on their pathway is minimised.** *(Appendix 1 - Checklist 2:4 refers)*
Outcome: • Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge. Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital. There is early engagement with SAS for ambulance discharge and transfer. Medical and Nurse Directors provide monthly report on ward by ward, in/out balance, daily discharge progress and performance.
Local indicator(s): • distributions of attendances / admissions; • distribution of time to assessment; • distribution of time between decision to transfer/discharge and actual time; • % of discharges before noon; • % of discharges through discharge lounge; • % of discharges that are criteria led; • levels of boarding medical patients in surgical wards.

10. **Communication plans** *(Appendix 1 - Checklist 2:7 refers)*
Outcome: • The public and patients are kept informed of winter pressures, their impact on services and the actions being taken.
Local indicator(s) : • daily record of communications activity; • early and wide promotion of winter plan

11. **Preparing effectively for norovirus.** *(Appendix 1 - Checklist 4 refers)*
Outcome: The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised through the effective implementation of the HPS Norovirus Outbreak Guidance (2016/17).
Local indicator(s): • number of wards closed to norovirus; • application of HPS norovirus guidance.

12. **Delivering seasonal flu vaccination to public and staff.** *(Appendix 1 - Checklist 5 refers)*
Outcome: • CMO uptake targets for seasonal flu vaccination for those aged 65 and above, at risk groups and front line staff are delivered in accordance with CMO Guidance.
Local indicator(s): • % uptake for those aged 65+ and ‘at risk’ groups; • % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.

3. Self-Assessment Checklists

3.1 The self-assessment checklists (Appendix 1) provide further detail to support the development of local winter plans. These checklists should be used by local governance groups to assess the quality of winter preparations and to ascertain where further action might be required. There is no requirement for these checklists to be submitted to the Scottish Government.

3.2 A National Unscheduled Care Event will be held on 8th September at Stirling Management Centre and will include sessions on a range of initiatives designed to support NHS Boards to effectively prepare for winter.

4. Winter Plan Sign-Off

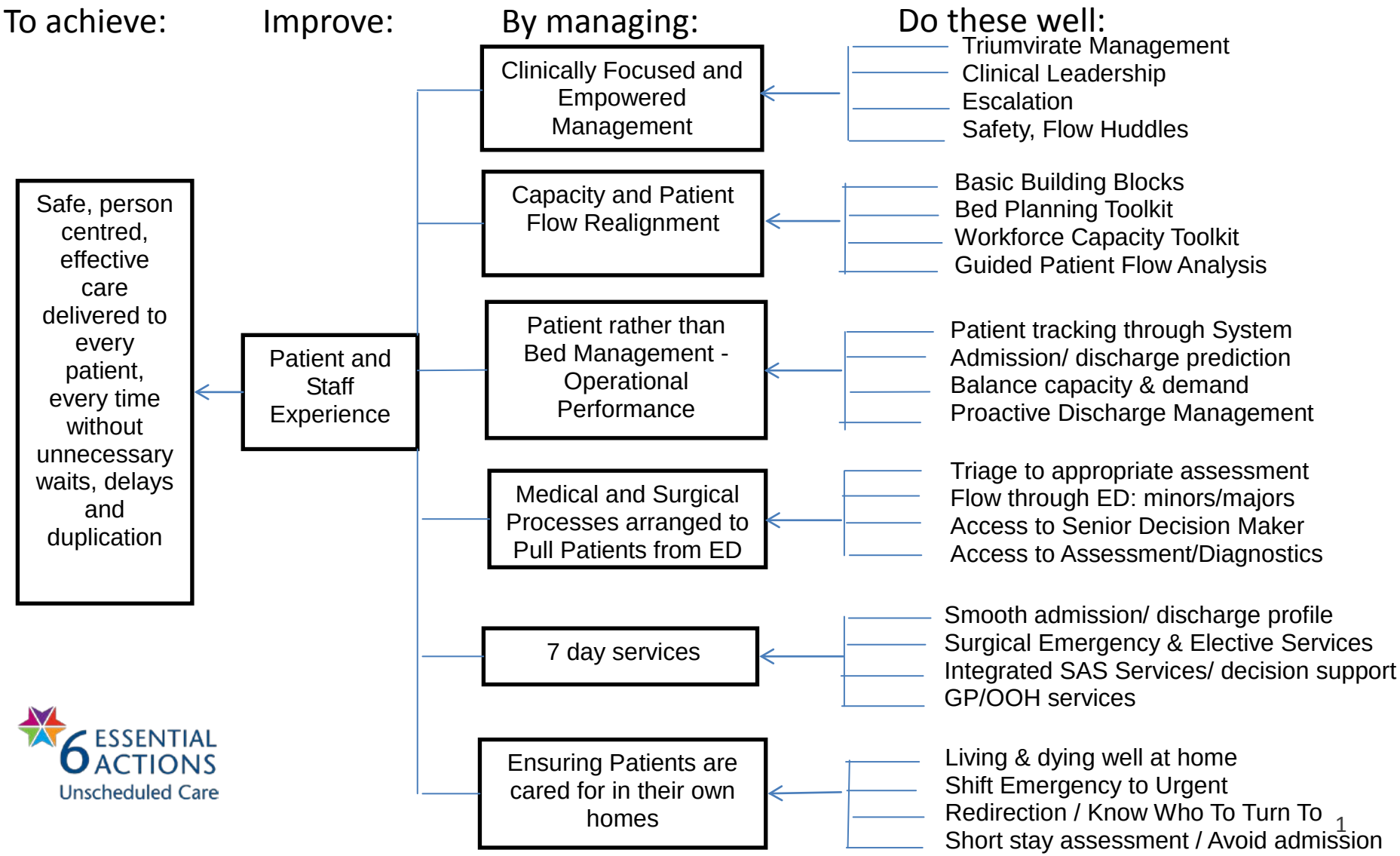
4.1 Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements and should be published online. Plans / links to plan(s) should be sent to Winter_Planning_Team_Mailbox@gov.scot .

4.2 I recognise the tremendous commitment made by the workforce across Health and Social Care services in meeting the challenges of winter and I would be grateful if you could pass on my appreciation of their dedication and valued contribution.

Annex A

healthier scotland
SCOTTISH GOVERNMENT

6 Essential Actions to Improving Unscheduled Care Performance



6 ESSENTIAL ACTIONS
Unscheduled Care

Appendix 1:

Preparing for Winter 2016/17

Winter Preparedness: Self-Assessment

Priorities

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **Seasonal Flu**
6. **Respiratory Pathway**
7. **Management Information**
8. **Sign-Off**
9. **Integration of Key Partners / Services**

These checklists should be read in conjunction with the Preparing for Winter 2016/17 Guidance.

- NHS Territorial Boards and Health & Social Care Partnerships should consider all of these actions, in detail, as part of their winter planning preparations.
- NHS Special Boards should review all of these actions to identify those most applicable to their own area of operations.
- Special Boards should also consider how they can best support Territorial Boards and Health & Social Care Partnerships across the full complement of actions and initiate supportive partnership working where required.

Winter Preparedness: Self-Assessment Guidance

- Local governance groups should use the attached checklists to self-assess the quality of overall winter preparations and to ascertain where further action is required to ensure that winter preparedness priorities are met.

- There is no requirement for these checklists to be submitted to the Scottish Government.

- Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements and should be published online. Plans / links to plan(s) should be sent to Winter_Planning_Team_Mailbox@gov.scot

- Winter Plans should consider the critical areas highlighted in the Preparing for Winter 2016/17 Guidance and demonstrate effective integration of key partners and services.

- The following RAG status definition table is offered as a guide to help you evaluate the status of your overall winter preparedness against each action.

RAG Status	Definition	Action Required
Green	Systems / Processes fully in place & tested where appropriate.	Routine Monitoring
Amber	Systems / Processes are in development and will be fully in place by the end of October.	Active Monitoring & Review
Red	Systems/Processes are not in place and there is no development plan.	Urgent Action Required

1	**Resilience Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	The partnership has robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather. These arrangements have built on the lessons learned from previous periods of severe weather, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details. The NHSScotland Standards for Organisational Resilience (2016) sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	☐ ☐		
2	Business continuity (BC) plans take into account the organisations critical activities; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios. Risk assessments take into account staff absences and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner. The partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.	☐ ☐ ☐		
3	The NHS Board and Local Authority have HR policies in place that cover: • what staff should do in the event of severe weather hindering access to work, and • how the appropriate travel advice will be communicated to staff and patients *Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.*	☐		
4	The NHS Board's website will be used to advise on travel to hospital appointments during severe weather and prospective cancellation of clinics.	☐		
5	The NHS Board and local authority have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors.	☐		
6	The partnership will test the effectiveness of its winter plan by 30 Oct with stakeholders. The final version of the winter plan has been approved by the Integration Joint Board.	☐		

2	Unscheduled / Elective Care Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	**Clinically Focussed and Empowered Management**			
1.1	Clear site management process is in place with operational overview of all emergency and elective activity. *Ideally this should be a triumvirate approach of operational, medical and nursing Directors/leads with autonomy to make decisions to manage the site*	☐		
1.2	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur escalation procedures are invoked.	☐		
1.3	Effective communication protocols are in place between key partners, particularly across local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector. *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☐		
1.4	A Target Operating Model has been communicated to all staff. Escalation policies are well defined, clearly understood, and well tested. *Clear thresholds and authorities for triggering, and standing down, escalation plans should be established and clearly communicated.*	☐		
1.5	Escalation policies are in place and consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU. *This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.*	☐		
1.6	Escalation policies are focused around in-patient capacity across the whole system. *Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay*	☐		
1.7	Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*	☐		

2	**Undertake detailed analysis and planning to effectively schedule elective activity (both short and medium-term) based on forecast emergency and elective demand, to optimise whole systems business continuity.** **This has specifically taken into account the surge in unscheduled activity in the first week of January.**			
2.1	Demand, capacity, and activity plans across emergency and elective provision are fully integrated. *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.* *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times being exceeded. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.* *Partnerships can evidence that for critical specialities scheduled queue size and shape are such that a winter surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*	☐		
2.2	A range of analysis and management tools to enable effective and related planning and management of scheduled and unscheduled services have been implemented. *e.g. Basic Building Blocks, Performance Toolkit, Statistical Process Control, Queuing Theory, Discreet Event Simulation, Variation Methodology, etc.*	☐		
2.2	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter surge beds for emergency admissions. *This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring.*	☐		
2.3	Pre-planning and modelling has been undertaken around elective activity to plan responses, escalation and recovery to minimise the impact of winter peaks in demand on the delivery of routine elective work. *A set of clear actions should be developed based on a firm understanding of demand and capacity, prediction and management of variation.* *In the event of severe weather impacting significantly on elective capacity, NHS Boards, should contact SGHSCD Access Support Team to advise of any service disruption*	☐		

2.4	Planning and analysis will facilitate the NHS Board to consistently deliver the 4 Hour Emergency Access target (95%) and work towards the (98% Standard), eliminate 12 hour breaches whilst avoiding 8 hour breaches, and maintain the delivery of all elective care. *NHS Boards are expected to maintain performance against all LDP standards, while recognising that clinical decision making in the interests of all patients is paramount. This includes TTG (legal requirement), 18 weeks, Diagnostics, Outpatients and Cancer.* *Monitoring of these measures is required to support escalation policies and achieve sustainable flow through the system.*	☐		
2.5	NHS Boards review and take stock of their performance against the British Association of Day Surgery (BADS) Directory version 4 to ensure that they have achieved optimum performance against the surgical procedures identified as being suitable for day case surgery" *Achieving optimal performance against BADS version 4 will support NHS Boards to manage bed occupancy, admission and discharge of elective patients.*	☐		
3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned activities such as MDTs, and projected peaks in demand. These rotas should include services that support the management of inpatient pathways, (e.g.) diagnostics, pharmacy, phlebotomy, AHPs, IPCT, portering, cleaning etc.**			
3.1	Consultant (Medical and Surgical) cover along with multi-professional support teams, including IPCT cover, will be planned to effectively manage predicted activity and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including impact of significant events (e.g.). Hogmanay Street parties on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*.	☐		
3.2	Extra capacity should be scheduled for the 'return to work' days after the four day festive break and this should be factored into annual leave management arrangements.	☐		
3.3	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc. *Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations*	☐		
3.4	Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinician/manager on call to ensure alternatives to attendance are considered.	☐		
3.5	Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of the TTG being breached.			

4	**Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge process which includes determining an Estimated Date of Discharge as soon as patients are admitted or scheduled for admission with supporting processes (e.g.) multi-disciplinary ward rounds. This will support the proactive management of simple discharge, ensuring there are no delays in patient pathways.**			
4.1	Discharge planning will commence at the point of admission, prior to admission or at pre-admission assessment using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.* *Utilise Criteria Led Discharge wherever possible.*	☐		
4.2	There will be on-going engagement with the SAS to effectively plan patient transport when it is known, or anticipated, that patients will require transport home or to another care setting. *Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process. Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.*	☐		
4.3	Multi-disciplinary Ward Rounds will be embedded to proactively manage the patient journey and prepare for discharge detailing the estimated date of discharge. Utilise electronic whiteboards. *This should be displayed visually for the care team to see and should be the focus of all daily ward rounds and bed meetings and inform daily safety flow huddles. Task lists should be available for all actions leading towards early discharge.*	☐		
4.4	Regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. *Ward rounds should follow the 'golden hour' format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge.*	☐		
4.5	Predictive data will be used to assess the hourly demand for beds allowing for discharges to be scheduled to optimise flow. *Consider evaluating the accuracy of EDD to help improve the discharge process.* *Develop in/out balance for each ward level to improve speciality receiving and minimise boarding.*	☐		

4.6	Discharge lounges should be fully utilised to optimise capacity pior to noon. *Processes should be in place to support morning discharge at all times (e.g.) breakfast club, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.*	☐		
5	**Ensure that senior clinical decision making capacity is available for assessment, care planning, MDTs and discharge and that AHP rotas are structured, to facilitate the discharging of patients throughout weekends and the fortnight in which the two festive holiday periods occur in order to maximise capacity.**			
5.1	There is adequate medical, nursing and AHP cover across both, the festive holiday period, and over weekends to conduct assessments, plan effective care programmes and perform dedicated discharge rounds. *Criteria-led discharges should be put in place wherever possible to improve discharge process across 7 day.*	☐		
5.2	Key partners such as: pharmacy, transport and social care services will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. *There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes*	☐		
6	**Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.**			
6.1	There is close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet predicted discharge levels. *This will be particularly important over the festive holiday periods.*	☐		
6.2	Ongoing and detailed engagement around the capacity of social care services to accommodate predicted discharge levels will start no later than October.	☐		
6.3	A clear escalation plan is in place to resolve issues that might arise. *Consideration should be given to developing local agreements on the direct purchase of homecare by ward staff.*	☐		

6.4	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised, where possible. *Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.*	☐		
6.5	Host partnerships are taking the discharge requirements of patients who are receiving treatment at the Golden Jubilee Foundation into account.	☐		
6.6	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge. *Anticipatory care plans are utilised to manage care pathways.*	☐		
6.7	All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances. *If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge hospital to inform home circumstances and fit for discharge.*	☐		
7	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
7.1	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as soon as they occur, and that escalation procedures are invoked at the earliest opportunity. *Utilise ED Capacity Management Guidance to develop whole system approach and response to crowding.*	☐		
7.2	Demand, capacity, and activity plans across emergency and elective provision are fully integrated. *Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.*	☐		
7.3	Effective communication protocols are in place between key partners, particularly across local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector. *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☐		

7.4	Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent. *NHS 24 are leading on the 2016/17 'Be Healthwise This Winter' media campaign, and SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around repeat prescriptions', respiratory hygiene, and norovirus are effectively communicated to the public.* *In late October the SG will launch its Resilience Campaign, in partnership with the British Red Cross, and other organisations to highlight the risks and consequences of all kinds of severe weather and the simple practical ways people can reduce these risks. Messages will continue to be targeted at more vulnerable and harder to reach people in our communities.* *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.*	☐		

3	**Out of Hours Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	The OOH plan covers the full winter period and pays particular attention to the festive period. *This should include an agreed escalation process.* *Have you considered/discussed local processes with NHS 24 on providing pre-prioritised calls during the OOH period?*	☐		
2	The plan clearly demonstrates how the partnership will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period.	☐		
3	There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed.	☐		
4	There is reference to direct referrals between services. *For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?*	☐		
5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.	☐		
6	There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa	☐		
7	Clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.	☐		
8	There is reference to provision of dental services, to ensure that services are in place either via general dental practices or out of hours centres *This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.*	☐		
9	The plan displays a confidence that staff will be available to work the planned rotas. *While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.*	☐		

10	There is evidence of what the partnership is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24. *This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.*	☐		
11	There is evidence of joint working between partnerships and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.	☐		
12	There is evidence of joint working between partnerships and NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*	☐		
13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*	☐		
14	There is evidence of working with social work services in preparing this plan. *This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*	☐		
15	There is evidence of clear links to the pandemic plan including provision for an escalation plan. *The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.*	☐		

4	**Prepare for & Implement Norovirus Outbreak Control Measures** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	Infection Prevention and Control Teams (IPCTs) should read the HPS Norovirus Outbreak Guidance due to be refreshed in September 2016.	☐		
2	IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in care homes.*	☐		
3	HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards. *Staff should be reminded of the need to remain absent for 48 hours post last symptom of Diarrhoea and vomiting. Where staff are prevented from returning to work NHS Boards should refer to the guidance note issued in 2010 relating to staff absence and infection control.*	☐		
4	NHS Board communications regarding bed pressures and norovirus ward closures are optimal and everyone will be kept up to date in real time. *Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*	☐		
5	Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital might also merit an evaluation.*	☐		
6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation.	☐		
7	Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge. *The SG HAI team has contacted the HOAG to request that they liaise with the SMVN to reach consensus around testing procedures for patients that have been in the vicinity of norovirus outbreaks.*	☐		
8	NHS Boards must ensure arrangements are in place to provide adequate IPCT cover across the whole of the festive holiday period. *While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards might wish to consider their local IPC arrangements.*	☐		

9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple wards over a couple of days. *As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.*	☐		
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. *This should include the notification of 'tweets' to help spread key message information.*	☐		
11	The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the 'Stay at Home Campaign' message. *This should include the notification of 'tweets' to help spread key message information.*	☐		

5	**Seasonal Flu, Staff Protection & Outbreak Resourcing** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	At least 50% of all staff working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients, as recommended in the CMOs seasonal flu vaccination letter due to be published in mid Aug 2016. *This will be evidenced through end of season vaccine uptake submitted to HPS by each NHS board. Local trajectories have been agreed and put in place to support and track progress. Uptake of vaccine in 2014/15 was still significantly below target, at 36.3%.*	☐		
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter (2014)12 clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake.*	☐		
3	The winter plan takes into account the predicted surge of flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period. *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required and an agreed protocol is in place with NHS Boards on the use of the contingency stock. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)*	☐		
4	HPS weekly updates, showing the current epidemiological picture on influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *Health Protection Scotland and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. HPS produce a weekly influenza bulletin and a distillate of this is included in the HPS Winter Pressures Bulletin.*	☐		

5	Adequate resources are in place to manage potential outbreaks of seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*	☐		

6	**Respiratory Pathway** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**			
1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.	☐		
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☐		
1.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times. *Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place..* *Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.* *Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).*	☐		
1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*	☐		
2	**There is effective discharge planning in place for people with chronic respiratory disease including COPD**			
2.1	Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation. *Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).*	☐		
2.2	All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team.	☐		

3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**			
3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data, https://www.bo.scot.nhs.uk/. This release estimates an individual's risk of emergency admission.* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*	☐		
4	**There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board**			
4.1	Staff are aware of the procedures for obtaining/organising home oxygen services. Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860) Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period. Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. *Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.*	☐ ☐ ☐ ☐		
5	**People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.**			
5.1	Emergency care contact points have access to pulse oximetry. *Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.*	☐		

7	**Management Information** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	Admissions data will be input to the System Watch predictive modelling system as close to real time as possible. Local quality assurance of the site and board level data is in place.	☐		
2	Effective reporting lines are in place to provide the Scottish Government with routine weekly management information and any additional information that might be required on an exception / daily basis. *Over the winter period we will be augmenting the weekly management information collected on an all-year-round basis and will share this information across partnerships to help compare and benchmark performance.*	☐ ☐		
3	Effective reporting lines are in place to provide the SG Directorate for Health Workforce & Performance with immediate notification of significant service pressures that will disrupt services to patients as soon as they arise. *Any exception reporting should be set within the context of planned / actual capacity and demand activity.*	☐		

8	**Sign Off** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements and should be published online.	☐		
2	Arrangements are in place to include governance of winter planning within local Unscheduled Care Management Groups or other relevant management groups as appropriate. *Membership of these groups should include national and local Unscheduled Care Teams where applicable.*	☐		

9	Key Roles / Services Integrated into Planning Process		RAG	Further Action/Comments
	Heads of Service	☐		
	Nursing / Medical Consultants	☐		
	Consultants in Dental Public Health	☐		
	AHP Leads	☐		
	Infection Control Managers	☐		
	Managers Responsible for Capacity & Flow	☐		
	Pharmacy Leads	☐		
	Mental Health Leads	☐		
	Business Continuity / Emergency Planning Managers	☐		
	OOH Service Managers	☐		
	GP's	☐		
	NHS 24	☐		
	SAS	☐		
	Territorial NHS Boards	☐		
	Independent Sector	☐		
	Local Authorities	☐		
	Integration Joint Boards	☐		
	Strategic Co-ordination Group	☐		
	Third Sector	☐		
	SG Health & Social Care Directorate	☐		

Appendix 2

Health & Social Care:
Winter in Scotland in 2015/16

Health & Social Care: Winter in Scotland in 2015/16

Summary

1. In winter 2015/16, the NHS in Scotland increased capacity and carried out more activity. Delayed discharge performance improved. Scotland saw significant A&E waiting times performance improvements compared to previous Winters. Preparing for winter, integrating health and social care and improving delayed discharge and supporting delivery of the six essential actions continue to be priorities for the Scottish Government.

Purpose

2. The Scottish Government aims to create the conditions which support NHS Scotland to improve resilience by building capability to absorb, respond and recover from disruptive challenges. Winter disruptions can include increased demand and activity due to seasonal flu, respiratory and circulatory illness; increased numbers of falls and trips; and wards closed to admission due to higher levels of norovirus. There are also business continuity challenges associated with managing workforce rotas during the festive period, to ensure that patients continue to be safely and effectively admitted, diagnosed, treated and discharged.

3. This report draws together the key official statistics on system capacity, activity, pressures and performance. Unless otherwise stated, within the charts and tables, winter is defined as the two quarters ending December and March.

Planning for Winter 2015/16

4. The Scottish Government and local partnerships reviewed the 2014/15 winter as part of the planning process for 2015/16.

5. The Scottish Government developed winter guidance with NHS Boards and their partners over the summer of 2015. Winter guidance was issued on 6 August 2015 which was almost 2 months earlier than in previous years. A National Unscheduled Care planning event was held on 17 September 2015. NHS Boards also published their local winter plans.

The NHS in Scotland strengthened capacity in Winter 2015/16

6. Between December 2014 and December 2015, the NHS Scotland workforce increased by 798.2 whole time equivalent (wte) or 0.6 per cent. This included an additional 173.7 wte Medical and Dental consultants (including Clinical Directors) and 283.6 wte nursing and midwifery staff (inc Interns). Over recent years there has been significant developments in the nursing and midwifery workload and workforce planning tools available to NHS Boards in Scotland. These evidence based tools provide information on the nursing and midwifery whole time equivalent requirement based on the measurement of workload generated by individual patients.

The NHS in Scotland delivered increased levels of activity in Winter 2015/16

7. Overall Scottish Ambulance Service emergency demand (Cat A, Cat B, Cat C) increased by 1,880 or 0.8 per cent compared to Winter 2014/15.

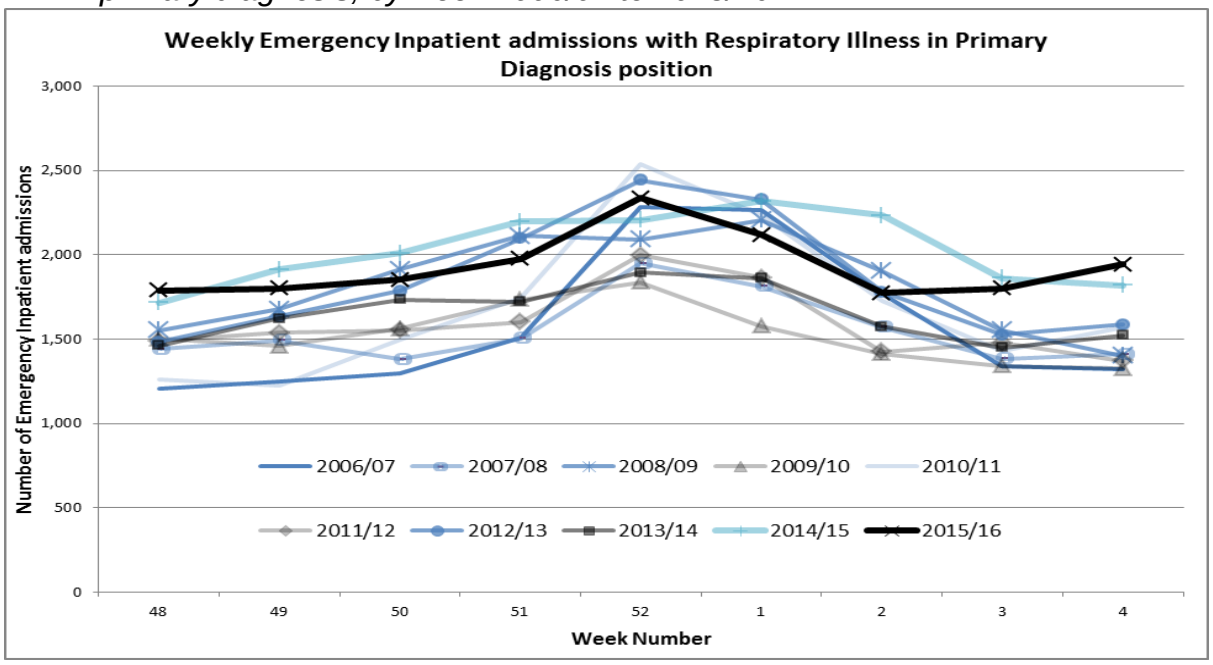
8. Hospital activity was also at an increased level. The numbers of A&E attendances and emergency inpatients increased. A&E attendances were up 6,055 or 0.8 per cent; emergency inpatient discharges up by almost 9,000 or 3.1 per cent this winter.

9. Calls to NHS 24 core services decreased by 9,021 or 1.1 per cent compared to last winter. During the period Oct 2015 – Mar 2016, 4 of the 6 months reflect this overall reduction, although January and March 2016 show an increase. Of these two months, March 2016 shows the higher year on year variance, an increase of approximately 11 per cent which was heavily influenced by Easter falling in this month, as opposed to in April in 2015.

Respiratory conditions and influenza are key winter factors

10. Weekly emergency inpatient admissions with respiratory illness are down on winter 2014/15 but remain above the recent long term average.

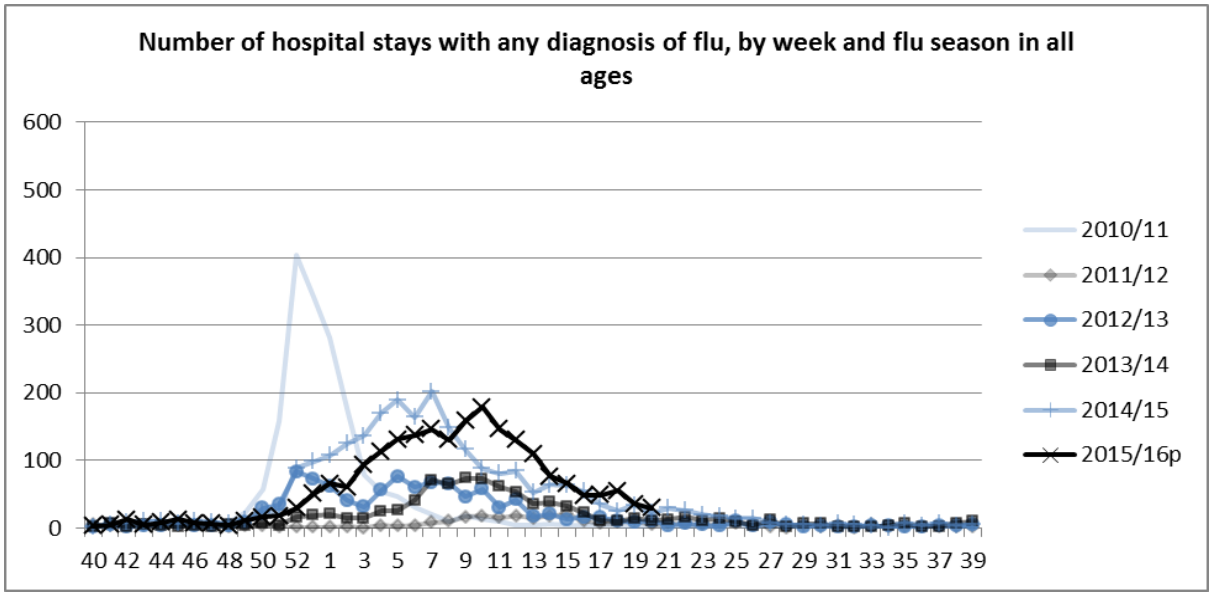
Chart 1: Weekly emergency inpatient admissions with respiratory illness as a primary diagnosis, by week 2006/07 to 2015/16



Source: ISD Scotland

11. Within the general community, impact on general practice was low and below the levels expected in a normal influenza season across the whole of the 2015/16 season. Provisional data on the number of influenza hospital admissions for 2015/16 is similar to 2014/15 and higher than previous seasons.

Chart 2: The Number of hospital stays with 'any diagnosis' of flu, by week and flu season, 2010/11 to 2015/16

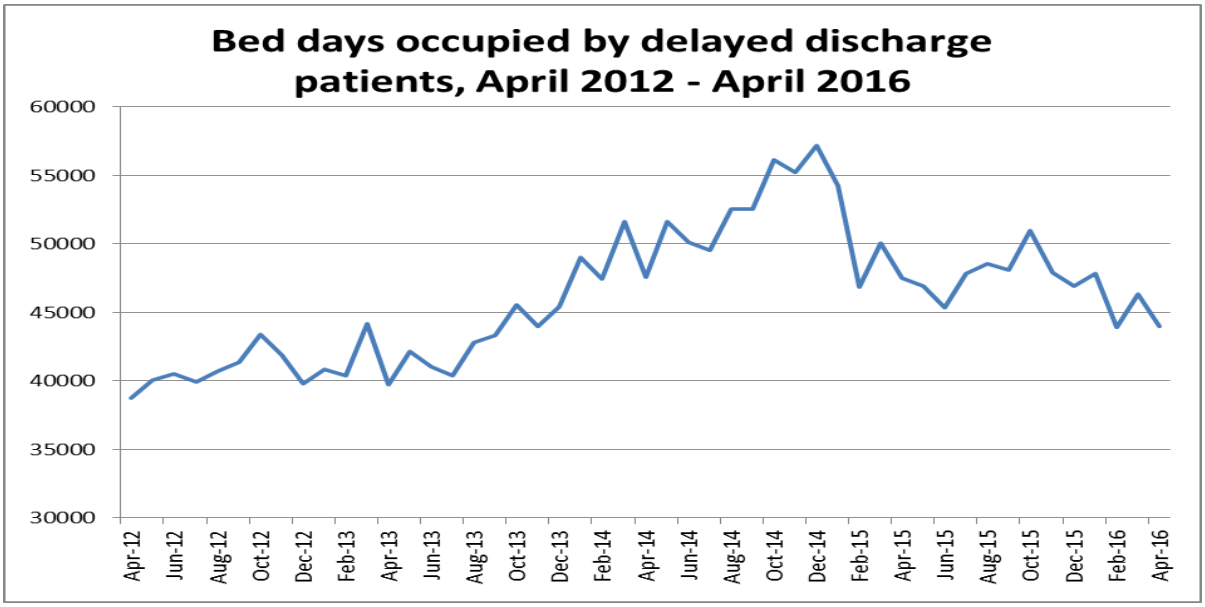


Source: Health Protection Scotland

Delayed discharge performance has improved

12. During winter 2015/16, the number of bed days occupied by delayed discharge patients have reduced to just 46,309 by March 2016. This was a large decrease from December 2014 of 57,187.

Chart 3: Bed days occupied by delayed discharge patients, April 2012 – April 2016



Source: ISD Scotland

Norovirus was relatively mild, and the weather was not particularly cold

13. The norovirus season 2015-16 was relatively low compared to the 2010-2015 season average. Significant effort has gone into improving norovirus outbreak prevention, preparedness, detection and management. The circulating virus strain is also key to determining how much impact norovirus will have on hospitals.

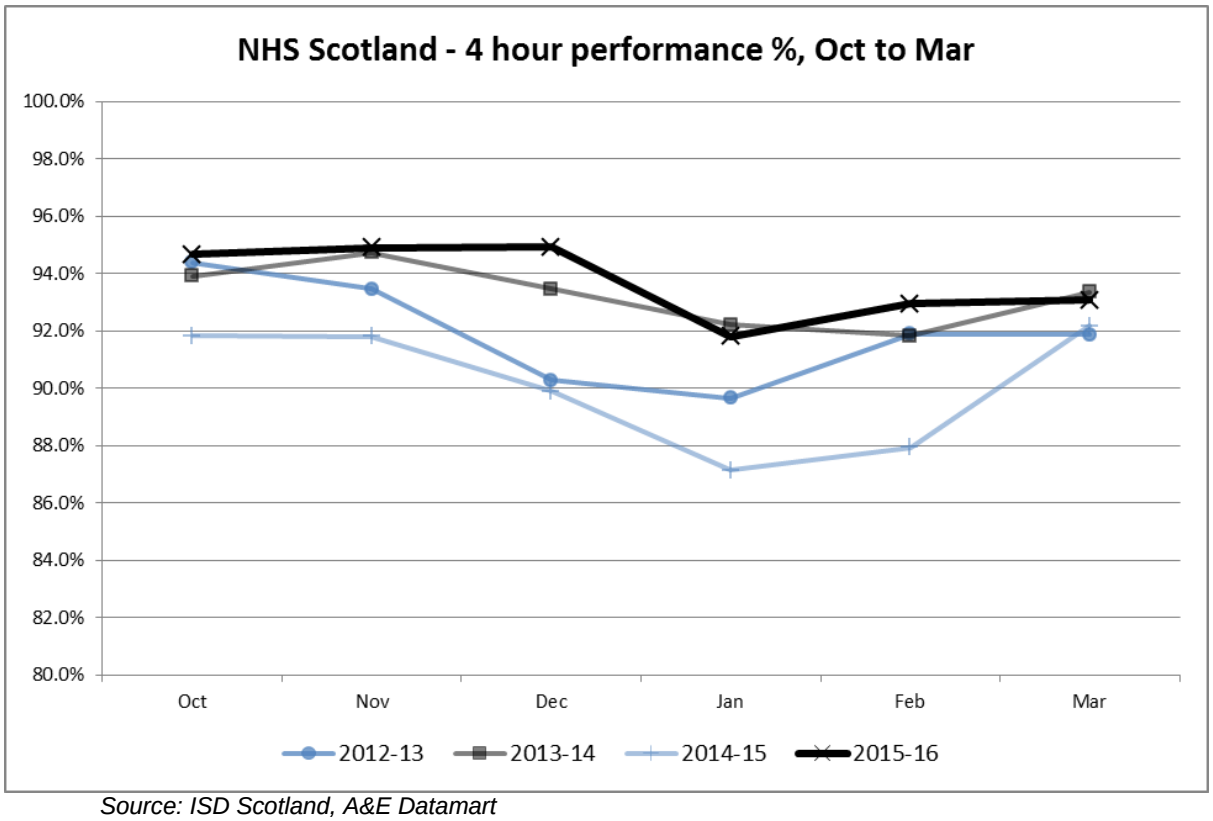
14. The average temperatures this winter were broadly comparable with the 30 year averages.

A&E waiting times performance improving significantly

15. The length of time A&E patients wait to be seen, treated and discharged can be a proxy measure of how the NHS is managing the pressures it is facing.

16. A&E waiting times performance improved significantly in 2015/16. Official statistics show 4 hour A&E performance over winter at its highest level since 2011/12.

Chart 4: NHS Scotland, 4 hour A&E performance, winter 2012/13 to 2015/16



Source: ISD Scotland, A&E Datamart

Core A&E waiting times performance was higher in Scotland compared to the rest of UK in Winter 2015/16

17. Official statistics on waiting times in large Accident & Emergency departments are published by each of the four UK countries. This report does not consider the nature of the pressures faced in other parts of the UK. This winter, performance in Scotland was well above that in England, Northern Ireland and Wales.

Table 4: UK A&E "Core" sites 4 Hr Performance, winter 2014/15 – 2015/16.

	'Winter' Oct-Mar 2014-15	'Winter' Oct-Mar 2015-16	Percentage point change
Scotland	88.9%	93.0%	+4.1
England	88.2%	84.6%	-3.6
Wales	79.3%	75.1%	-4.2
Northern Ireland	71.7%	70.4%	-2.0

Source: ISD Scotland, NHS England, NHS Wales Informatics and DHSSPSNI

Elective and cancer waiting times remained stable over winter

18. Statistics for January to March 2016 show that 92.7 per cent of inpatients and day-case patients were treated within 12 weeks this compares to 94.6 per cent for July to September 2015. Statistics also show 88.0 per cent of patients waiting for a new outpatient appointment at 31 March 2016 had been waiting 12 weeks or less, compared to 86.1 per cent at the end of September 2015. For January to March 2016, 62 day performance for Cancer Waiting times was 90.2 per cent, which was the same level as for the quarter ending September 2015.

Season Flu Vaccination

19. Early data on seasonal flu uptake by staff in 2015/16 was 32.0 per cent. This represents a decrease on 2014/15 when uptake was 35.6 per cent, and overall recorded uptake remains low and below the 50 per cent target. Some individual Boards consistently achieve higher levels of uptake, which may reflect local circumstances, but it may also reflect the initiatives and approaches adopted.

20. Last winter more than two million Scots were offered the free flu vaccine. People at greater risk from flu, including those with underlying health conditions, pregnant women and those aged 65 were encouraged to get the vaccine. Provisional uptake rates are shown in the table below.

Table 7: Provisional seasonal flu uptake rates, 2015/16

Eligible Groups	Uptake	Target
65 and over	74.5%	75%
Under 65 at risk	48.0%	75%
Pregnant Women (without risk factors)	49.9%	75%
Pregnant Women (with risk factor)	61.5%	75%
2-5 year olds (not yet at school) – vaccinated at GP practice	57.1%	65%
Schoolchildren aged 5-11 (P1-P7) – vaccinated at school	71.5%	75%

*Source: HPS (**National Influenza Report - week ending 22 May 2016)***

References

1. Acute Hospital Activity and NHS Beds Information Quarter ending March 2016

Quarterly trends in available beds
https://www.isdscotland.org/Health-Topics/Hospital-Care/Publications/2016-06-28/Quarterly_trends_in_available_beds_Jun16.xlsx

Quarterly Inpatient, Day Case and Outpatient Activity
https://www.isdscotland.org/Health-Topics/Hospital-Care/Publications/2016-06-28/Quarterly_NHS_inpatient_activity_hbt_Jun16.xlsx

https://www.isdscotland.org/Health-Topics/Hospital-Care/Publications/2016-06-28/Quarterly_NHS_outpatient_activity_hbt_Jun16.xlsx

2. NHS Scotland Workforce Information - Quarterly update of Staff in Post, Vacancies and Turnover at 31 March 2016

Overall Trend
https://www.isdscotland.org/Health-Topics/Workforce/Publications/2016-06-07/Overall_Trend_M2016.xls

Consultant staff in post
https://www.isdscotland.org/Health-Topics/Workforce/Publications/2016-06-07/Consultant_Staff_In_Post_M2016.xls

Nursing and midwifery staff in post
https://www.isdscotland.org/Health-Topics/Workforce/Publications/2016-06-07/Nursing_and_Midwifery_SIP_M2016.xls

3. Emergency Department Activity and Waiting Times

Emergency Department Activity and Waiting Times data (Excel file)
http://www.isdscotland.org/Health-Topics/Emergency-Care/Publications/2016-06-07/AE_activity_waiting_times_Jun16.xlsx

4. NHS Performs - Weekly Update of Emergency Department Activity and Waiting Times Statistics

2016-06-28 Weekly AE Statistics
http://www.isdscotland.org/Health-Topics/Emergency-Care/Publications/2016-06-28/2016-06-28-ED-Weekly-Statistics.xlsx?13:34:05

5. NHS England, A&E Attendances and Emergency Admissions 2015-16

https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2016/06/April-AE-Timeseries.xlsx

6. Time Spent in NHS Wales Accident and Emergency Departments: Monthly Management Information

http://www.infoandstats.wales.nhs.uk/docopen.cfm?orgid=869&id=292299

7. NHS Northern Ireland, Statistics on Emergency Care Waiting Times by Department & Month

https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-nitws-ecwt-tables.csv

8. Delayed Discharges in NHSScotland - Occupied Bed Days in April 2016 and census Figures for May 2016

Bed Days Occupied in April 2016
https://isdscotland.scot.nhs.uk/Health-Topics/Health-and-Social-Community-Care/Publications/2016-06-21/BedDays_Occupied_Tables_To_Apr_2016.xlsx

Delayed Discharges in May 2016
https://isdscotland.scot.nhs.uk/Health-Topics/Health-and-Social-Community-Care/Publications/2016-06-21/DD_standard_and_code9_May2016.xlsx?40096683

9. Mid-2015 Population Estimates Scotland

All Tables
http://www.nrscotland.gov.uk/files//statistics/population-estimates/mid-15-cor-12-13-14/15mype-cahb-all-tab.xlsx

10. Inpatient, Day case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 31 March 2016

Inpatient and Day case admission: Waiting Times and Activity, NHS Scotland
http://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/2016-05-31/IPDC_May16.xlsx

11. Influenza

HPS National Influenza Report - week ending 22 May 2016
http://www.documents.hps.scot.nhs.uk/respiratory/seasonal-influenza/flu-update/2016-05-26.pdf

12. Norovirus

Weekly Norovirus Report – 27 June 2016
http://www.documents.hps.scot.nhs.uk/respiratory/seasonal-influenza/flu-update/2016-05-26.pdf

13. UK Climate Summaries

http://www.metoffice.gov.uk/climate/uk/summaries/anomacts

Winter Plan 2016/17

NHS Tayside Unscheduled Care Resilience Improvement & Plan

8/31/2016

This document is owned by NHS Tayside and Health and Social Care Partnerships in Angus, Dundee and Perth and Kinross. This document forms the basis of NHS Tayside winter plans for the period 2016/17. This plan is support by a readiness assessment completed in August 2016 and unscheduled care improvement plan. This document is also supported by standard business continuity plans.

Contents

Introduction 3
Policy Context 4
Purpose 5
Winter Analysis 2015/16 6
Governance Infrastructure for 2016/17 7
Improvement Plan 7
Essential Action 1 8
Essential Action 2 9
Essential Action 3 11
Essential Action 4 12
Essential Action 5 13
Essential Action 6 14
Unscheduled/ Elective Care Preparedness Unscheduled/ Elective Care Preparedness – Resilience planning 17
Effective communication 17
Out of Hours Preparedness 18
Preparing for and Implementing Norovirus Outbreak Control Measures 20
Seasonal Flu, Staff Protection and Outbreak Resourcing 21
Respiratory Pathway 22
Measures 23

Introduction

This plan describes the joint approach to planning for “winter” by NHS Tayside and the Health and Social Care Partnerships of Angus, Dundee and Perth & Kinross. The plan forms our local Unscheduled Care Action Plan, is aligned to our Five Year Transformation Plans and is underpinned by the Six Essential Actions for Unscheduled Care. This plan has been written taking full account of the winter planning guidance ‘The National Unscheduled Care Programme: Preparing for winter 2016/17’ (DL (2016) 18) and the supporting ‘Winter Preparedness: Self-assessment framework issued by the Scottish Government.

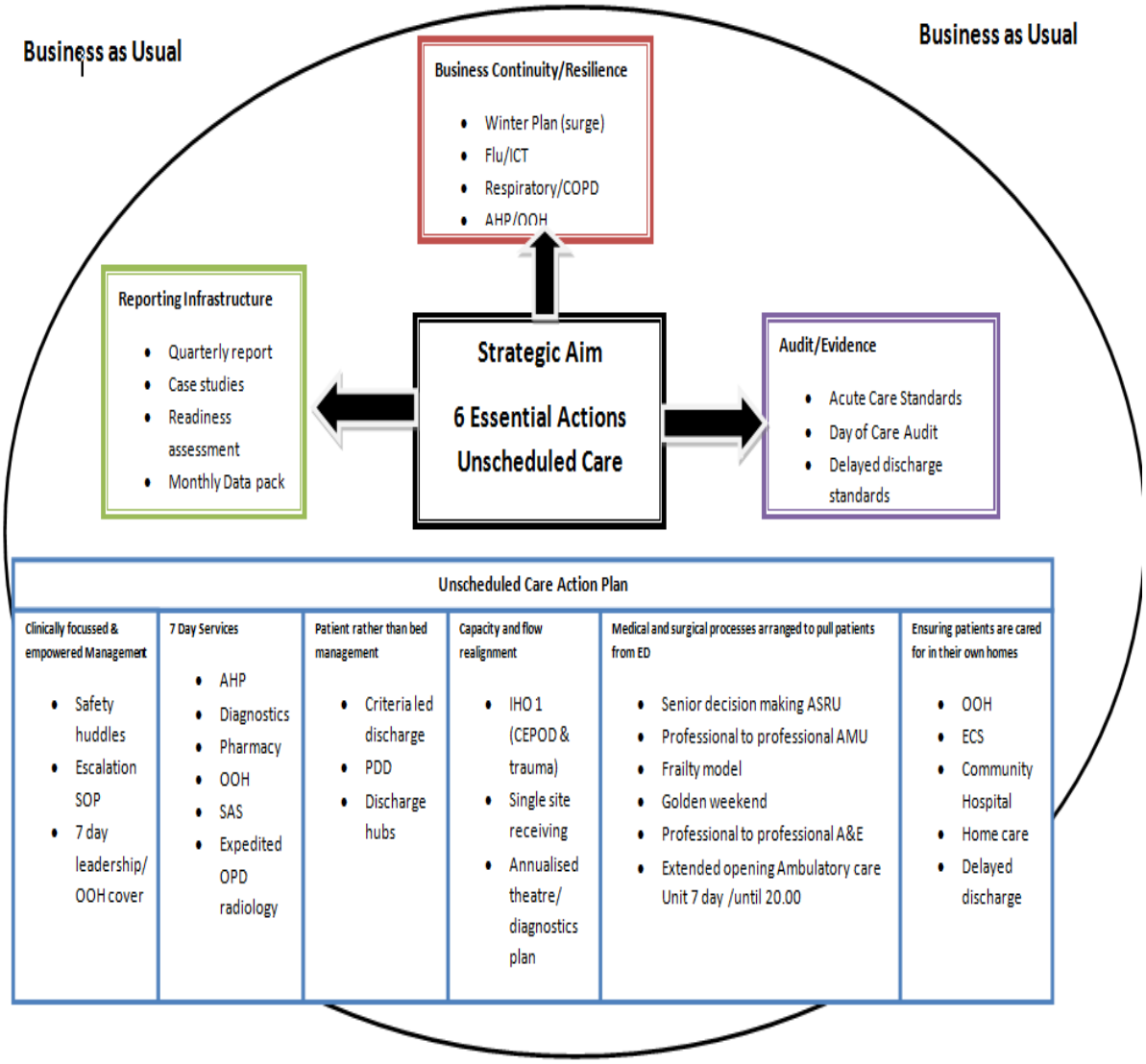
The plan is a whole system health and social care response to ensure we meet the needs of our population, in particular for the frail elderly and those who are acutely ill over the winter period. The plan aims to build resilience through effective planning to ensure the needs of our population are met. Our plan aims to provide safe and effective care for people using services by ensuring effective levels of capacity and resources are in place to meet expected activity levels.

We recognise that winter is not the only time when activity rises and services can be challenged to deliver timely access. It is therefore our intention through an overarching unscheduled care improvement plan to put in place the necessary transformational changes required to be able to respond to periods of high demand and events such as outbreaks and adverse weather whenever they occur. The plan is a dynamic document that represents the whole system to improve unscheduled care delivery as we progress to embed actions as business as usual. This plan is underpinned by full business continuity arrangements and daily management of capacity and flow through our established leadership and safety and flow infrastructure.

The Winter Plan 2016/17 aims to support the best use of locally available resources as demand rises and /or capacity is limited in order to sustain safe, effective and person-centred care in line with our quality ambitions. The approach has been to create systems and process with an underpinning system-wide response to increased demand or capacity pressures with an escalation framework for health and social care with agreed actions and triggers.

This Winter Plan will be supported by a suite of measures across the system which will enable informed decision-making implemented through our safety huddle framework which includes escalation processes (see appendix 1). This will be supported by weekly look back to encourage system learning and continuous improvement.

The following diagram represents the ambitions against the winter plan:



Policy Context

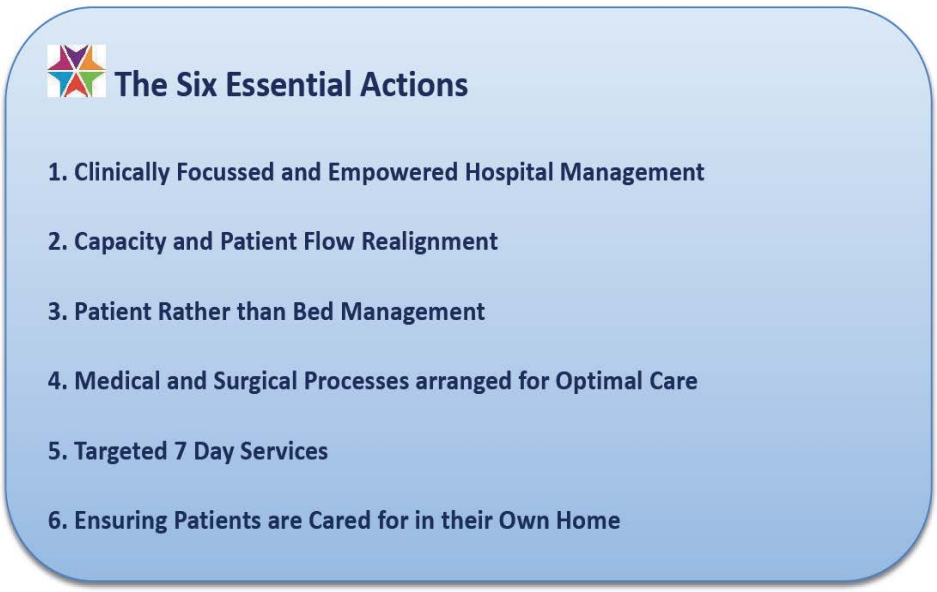
The 2020 Vision for Health and Social Care describes a health and social care system which is centred on:

- Integrated health and social care services
- A focus on prevention, anticipation and supported self-management
- Day case treatment as the norm where hospital treatment is required, and cannot be provided in a community setting
- Care being provided to the highest standards of quality and safety, with the person at the centre of all decisions
- Ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

This is a key thread through our Local Delivery Plan, Five Year Transformation Plan and the Strategic Improvement Plans of the Health and Social Care Partnerships in Perth & Kinross, Dundee and Angus. Specific to this winter plan are the following standards:

- People diagnosed with cancer are treated within 31 days from decision to treat (95%) 62 days from urgent referral with suspicion of cancer (95%)
- 12 weeks Treatment Time Guarantee (TTG 100%) 18 weeks Referral to Treatment (RTT 90%) 12 weeks for first outpatient appointment (95% with stretch 100%)
- 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
- Zero delayed discharges over two weeks and working toward discharge from hospital within 72 hours of being ready for discharge.

The improvement plan takes its direction from the Six Essential Actions for Improving Unscheduled Care. The Six Essential Actions are:



Purpose

The aim of the Winter Plan 2016/17 is to assure our board and the population of NHS Tayside have plans and systems in place to support the early intervention and action at points of pressure to minimise the potential disruption to services, people who use our services and their carers. All of these elements are strengthened by our board contingency and resilience planning for 2016-17.

The focus of the plan is therefore to:

- Ensure that people get the right care, at the right time, in the right place, avoiding unnecessary admissions to hospital and ensuring that, once admitted, people are discharged as soon as they are ready, contributing to better health outcomes and making best use of resources
- Ensure sustainable delivery of the 98% performance against the four hour Emergency Access Standard
- Increase the percentage of people who are discharged within 72 hours of being ready and reduce the bed days associated with delays
- Deliver a balanced approach to the effective planning and scheduling of elective and unscheduled care

- Introduce forward planning to meet care requirements over the festive period for respiratory, circulatory and ICU pathways, 31 day and 62 day cancer waiting times including the use of anticipatory care planning

An analysis has been undertaken to plan capacity and demand levels for this winter including explicit plans around the capacity required for unscheduled care for winter, including staffed medical and intermediate care beds, care packages, home care services accessible by GPs/NHS 24 and next day GP and hospital appointments.

Winter Analysis 2015/16

A review of our plans for Winter 2014/15 was undertaken by NHS Tayside

What worked well and we need to learn from?

- Site-based hospital management structures, safety and flow huddles tested in Perth Royal Infirmary, PRI and real-time information sharing through the eWhiteboards were vital to the supporting the prioritisation of resources and effective decision-making.
- Weekend pharmacy support to provide discharge support on a Saturday.
- A temporary re-allocation of 6 - 12 beds from Orthopaedics to Medicine made a contribution to patient flow but staffing challenges were experienced in this area.
- Additional resources were allocated to Scottish Ambulance Service (SAS) and an enhanced service was provided.
- Additional resources were allocated to diagnostics services to create more urgent outpatient slots to support early discharge and diagnosis.
- Non recurring funding was used to support Allied Health Professionals (AHP) services which supported earlier assessment and discharge.
- Enhanced Community Support Model (ECS) in our three Partnerships allowed people to stay in their own home as an alternative to the acute hospital.
- Additional home care provision was made available.
- Single site Out of Hours (OOH) GP service in place in Dundee to ensure cover of rotas and delivery of service for the whole of NHS Tayside – this was to ensure clinical shifts were covered over the Festive period (22nd December to 4th January).
- The Frailty model operated during Winter 2015/16 in the Acute Medical Unit (AMU) which was effective in preventing unnecessary admissions.
- Ambulatory care pathways within the AMU supported by professional to professional calls supported patient signposting to most effective care service and prevented unnecessary admissions.

What worked less well and we need to address?

- Weekly discharge meetings which enabled closer working between Acute Services and Partnerships was not fully in place across all Partnerships
- The PRI improvement plan was delivered in April following a Rapid Improvement Event which proposed changes which need to be implemented this winter
- Site-based hospital management structures tested in PRI only and needs to extend to Ninewells Hospital for winter 2016/17
- Seven day management and professional leadership infrastructure was not in place to support equitable decision and relied on on-call arrangements rather than on site presence
- Safety and flow huddles tested in PRI Monday – Friday only. This now needs to extended across the whole system seven days per week to ensure effective whole system decision-making
- Consultant, middle grade and trainee vacancies remained a significant challenge throughout Winter 2015/16. This will continue to be a challenge over 2016/17.

Targeted recruitment campaigns are in place to enhance normal recruitment to try to address this

- Nursing vacancies remained a challenge despite recruitment all available newly qualified practitioners (NQP), particular strain is placed on these roles as the graduation and registration means they start their new job right at the beginning of the busy winter pressure period
- The use of orthopaedic capacity (Ward 16) through compression of orthopaedic footprint to release beds to medicine compromised orthopaedic pathways and led to patient boarding out with speciality and cancellations of elective surgery
- Demand for unscheduled care across the whole acute system was such that elective work was compromised, particularly on the PRI site. This was further exacerbated by the level of delayed discharges on the site
- Increased delays in home care provision to support discharge were experienced, despite increased resource
- There were gaps in the out-of-hours (OOH) clinical staff particularly over the festive periods.
- Due to capacity pressures a number of patients were boarded out with their speciality.

Governance Infrastructure for 2016/17

- An Unscheduled Care Board is being established chaired by the Medical Director, Operational Unit and Head of Service, Health and Community Care, Dundee Health & Social Care Partnership to build on the plan
- The three Health and Social Care Partnership Chief Officers and Chief Operating Officer will continue to oversee the plans and meet on a monthly basis
- Resilience and business continuity arrangements and management plans are in place and will be tested prior to winter. A resilience planning awareness session is being run on the 15 November 2016 for all senior staff with an open invitation for all managers and those who participate in duty and executive on call rotas to attend
- Chief Officers Group in place for Perth & Kinross with established attendance and contribution from the General Manager and Associate Nurse Director for Perth Royal Infirmary (PRI)
- A Tayside wide severe weather plan is in place including triggers for multi-agency coordination
- Plans are tested in preparation for seasonal pressures
- Divert protocol has been developed for PRI and Ninewells
- Standard operating procedures and action cards are in place to support decision making and escalation process.
- Hospital safely and flow huddles to be implemented across seven days PRI and Ninewells Hospital.
- Staffing levels, bed model and escalation protocol being established for services underpinned by the implementation of safe care and the rostering system
- Supporting human resource policies are in place covering severe weather, adverse conditions and service disruption
- Communications plan and website to inform the public and our staff on planning for winter, where to go for services and key public health messages

Improvement Plan

The next section outlines the unscheduled care improvement plan against each of the 6 essential actions. The plan covers elements from each Health and Social Care Partnership and NHS Hospital sites.

Essential Action 1

Clinically focused and empowered hospital management will be particularly important where critical decisions relating to capacity through increased pressure over the festive period. Our arrangements aim to ensure effective leadership and management to help inform proactive decision making of patient safety, flow and capacity.

What is in place?

- Triumvirate site management - this is in place in PRI with General Manager, Associate Nurse Director and Clinical Lead and will be extended to the Ninewells site from November 2016
- Health and Social Care Partnerships are now established with integrated management teams and weekly capacity and discharge meetings are established in PRI and Ninewells, Dundee and Angus. These weekly meetings highlight and respond to challenges in delayed discharges
- NHS Tayside's Board Assurance framework has a corporate risk related to Perth Royal Infirmary. A scoring system has been developed for the key measures to enable an overall risk score to be presented
- A daily huddle framework is in place with attendance from senior clinical decision makers. The infrastructure of huddles take place at 08.00, 13.30, 16.30 and 21.30 Monday to Friday to identify and respond to safety concerns and system pressures. Health and Social Care Partnership employees are participating in daily huddles. This will be extended across seven days from November 2016
- *System Watch*[1] predictors are utilised to anticipate the level of emergency admission. Utilising the improved communication and leadership of the safety huddles, has ensured a focus on proactive discharge planning including, pre noon discharges, weekend discharges, utilisation of discharge lounge (Ninewells) and criteria led discharge
- An Unscheduled Care Programme Board being implemented Chaired by the Medical Director, Operational Unit and Head of Service, Health and Community Care, Dundee Health & Social Care Partnership with representation from acute and partnership services, Scottish Ambulance Service, Voluntary Sector and other key stakeholders to facilitate the identification of further opportunities for improvement
- 98% performance against the four hour standard is a priority for NHS Tayside linked to patient safety outcomes. Where there are waits out with the four hour standard these are reviewed, lessons learned and disseminated. There is regular daily and weekly review of performance
- Weekly meeting between Medicine for the Elderly Consultants (MFE) and Psychiatry of Old Age (POA) to discuss delays in discharge and capacity across the two services in PRI

What we will put in place for winter 2016/17

- Triumvirate site management in Ninewells with Site Manager, Associate Nurse Director and Clinical Lead
- Reorganisation of acute hospital management arrangements to ensure a site-specific approach and senior management and professional presence, including the weekend daytime hours and with 24 hour on-call support

[1] www.isdscotland.org/Products-and-Services/**System**-**Watch**

- An unscheduled care programme manager will be recruited to support continuous improvement and implementation of the winter plan
- A review of support services such as portering, cleaning, pharmacy and transport will be undertaken to ensure capacity is aligned to demand, not just within hours, but also across seven days and out-of-hours periods

Essential Action 2

Hospital capacity and patient flow (emergency and elective) realignment relies on our ability to use data and modelling to develop the [2]Basic Building Blocks (BBB) model to understand the capacity and demand of each site compared with recent years activity levels and improvements in flow and trends over three to five years.

What is in place?

- NHS Tayside has implemented a programme of change using operations management science methodology in conjunction with a technical partner, the Institute for Healthcare Optimisation (IHO) and the Scottish Government. This has given us the opportunity to review all of our main hospital sites to understand utilisation and clinical service delivery for unscheduled care. In particular how to balance resources and manage flows of time sensitive unscheduled or cancers cases and continue to deliver elective scheduled surgeries in line with treatment time guarantees and quality care
- A programme to understand how best we deliver scheduled and unscheduled general surgical flows to ensure safe and high quality care, at reasonable cost to meet changes in demand through seasonal fluctuation and increased demand for surgical services is being progressed. The business case to this for acute general surgery surgical receiving will be considered by NHS Tayside Board at its meeting in October 2016
- We have begun a programme of "realistic medicine"[3]. We have benchmarked our surgical services and recognise that variation exists particularly between hospital sites. Variation is not necessarily bad however we want to ensure that where best practice exists that it is spread and where unnecessary variation exists we reduce that.
- Surge capacity will be created this year through a focus on reducing delays in in-patient journey by working in partnership across health and social care and through implementing the improvements made following the Day of Care Audits
- The Hub Group (Dundee/Angus Discharge Task & Finish Group) hold priority huddles weekly. Perth also hold priority huddles each week
- Capacity and flow realignment to identify surge capacity within the system and how this will be appropriately addressed through the deployment of doctors, nurses and allied health professionals (AHP)
- NHS Tayside has conducted acute care standards audit across our whole system to review compliance and gaps for improvement
- Audit of patients discharged from Angus hospitals in July 2016 highlighted that 71% were discharged within 72 hours of being ready for discharge

[2] See: The National Unscheduled Care Programme: Preparing for winter 2016/17' (DL (2016) 18
[3] Chief Medical Officer's Annual Report 2014-15.www.gov.scot/Resource/0049/00492520.pdf

What we will put in place for winter 2016/17

- Staff rotas are planned in advance including safe staffing model to manage predicted activity, supporting this is the proactive deployment of NQP's into key specialty areas with a full and robust induction plan to support transition into registered nursing roles
- Seven day services will be targeted to priority areas to reduce variation in weekend and out-of-hours working for AHP services and diagnostics
- Pharmacy cover will be available over the festive weekend that will double our weekend staffing to six staff who will be on site from 10am -2pm. Christmas day and New Year day there will be one pharmacist and one dispenser for two hours 11.30am -1.30pm and the 26 December, 27 December, 2 January and 3 January we will be open with satellite dispensary staff of two pharmacists, two technicians and two ATOs from 9am – 2pm.The Christmas day service and New Year's day service will be a discharge and emergency item service only. This is to allow patients admitted after we close on Christmas and New Years Eve to be discharged. We have plans in place to cover AMU with extra sessions on a Saturday with a technician and a pharmacist from January - March 2017
- Learning from last year winter plan and anticipated surge demand within the orthopaedic service has led to redesign of orthopaedic floor. On Ninewells site elective and trauma have now been separated. There is a male trauma and a female trauma ward. The GP bay is now equipped with trolleys as an assess-to-admit model. Recruitment to a trauma nurse coordinator role is underway which will also enhance patient flow. The wards have been designed such that there would be flexible expansion capacity within the current staffing models to mitigate any orthopaedic patient being placed out-with speciality. The PRI wards have also been redesigned to match capacity to demand and separate elective and trauma patient flows
- Weekly meetings established with Emergency Department (ED) and Clinical Service Manger to discuss any surgery or orthopaedic related wait times in ED
- Establishment of Theatre Admission Suite (TAS) for surgery and orthopaedic patients to reduce overcrowding on wards on day of admission and / or admitting day before surgery for non clinical reason
- Day of Care Audit[4] completed, final report awaited and action plan being developed
- Cancer/urgent patient flow during festive period with MDT meetings during festive period. Within colorectal a generic email has been set up for specialist nurses to manage any urgent queries/patients. Festive period leave planned to ensure cancer tracking team, specialist nurses and consultants are available to ensure no delays in patient journey
- Transport arrangements to be discussed with patients at pre admission, e.g. pre assessment clinics/out-patients to ensure all journeys meet the criteria for SAS transport services
- In Dundee we have put in place an integrated AHP model for enablement and rehabilitation in Dundee community; co-located enablement, social work and health OT and community physiotherapy providing single point of access to improve access, reduce duplication, share skills and support more elderly people at home
- Additional home care packages and ability to increase capacity through the use of intermediate care beds
- We will test a discharge hub model in Perth and move towards an integrated intermediate care model
- We are working closely with the SAS to manage capacity and determine changes to SAS service that support more evening and weekend discharges
- Annualised diagnostics plan that support increases diagnostic services for the winter periods i.e. urgent outpatient CT slots

[4] www.**dayofcare**survey.scot.nhs.uk

- Data modelling using BBB framework to assess system capacity and medical pathway process mapping- respiratory, MFE, cardiology and gastroenterology
- Repeat Day of Care Audit to take place 25 October in PRI (second audit first conducted in April 2016) to inform where further improvements are required
- Safety huddle measurement plan linked to BBB analysis and system watch prediction
- Continue with discharge audits in Angus
- Review reasons for out-of-ours admissions with the aim to further identify the relative contributions of internal and external factors. The outcome will enable the pathway to focus on reducing avoidable emergency admissions
- Review the medical model for Community Hospitals in Perth & Kinross

Essential Action 3

Following and facilitating the patient journey (flow) rather than bed management should be founded on early morning coordinated planning and hospital safety huddles. Discharge-hub facilities, discharge prescriptions, discharge lounges, professional leadership and liaison with the ambulance service should be planned effectively on a seven-day-a-week basis to ensure no delays in care occur.

Discharge should be planned according to the patient's clinical condition. This means that patients should be discharged at the optimal time, with discharges before noon and over the weekend period consequently becoming more common. Using effective processes (electronic where possible) to track patients through their pathways ensures that operational grip and control is maintained.

What is in place?

- Safety huddles four daily Monday – Friday with a clear focus on 'no delays' and discharge supports optimising flow and proactively managing discharge promoting two before 10 and two before 12 discharge promoted at daily huddle – daily monitoring of am discharges
- Day of Care Audit completed in PRI & Perth & Kinross community hospitals in April 2015 to inform changes. A further audit to be undertaken in October (PRI) to assess sustainability of changes
- MfE consultant in place in Perth to support management of frail elderly patients working between acute and primary care setting /community hospitals – this mirrors the model for Dundee and Angus
- Consultant led ward rounds in place twice daily for acute admission areas across all of our sites
- AMU model in place including ambulatory care unit
- Joint coordinated discharge hub in Dundee and Angus in place jointly with social work
- Rapid Improvement event held in PRI with a focus on flow and discharges
- Theatre admission suite (TAS) and Day of Surgery Admission (DOSA) now in place for Ninewells supporting reduction in elective length of stay
- Agreement of additional resources to support extended Scottish Ambulance Service is planned to support people returning home over extended days and weekends
- The Intermediate Care and Enablement Service (ICES) ensure direct access to home care, intermediate care beds and rehabilitation to support discharge for Perth and Kinross

- There has been a strong focus on anticipatory care planning and identification of 'at risk' individuals through [5]SPARRA and other mechanisms are shared and proactively managed though social work-GP liaison arrangements and e-KIS
- Multi-disciplinary ward rounds are standard practice in all medical specialties
- Individuals who are likely to be suitable for weekend discharge are identified by general medicine teams at the end of the week for further review and discharge over the weekend
- Partnerships are working together to facilitate seven day discharge across settings and pre-planning in relation to public holidays
- Electronic whiteboards have been implemented in all acute wards and in most community hospital settings that support improved communication and information
- Acute care standards audit Ninewells and PRI completed with clear understanding of compliance and improvement required

What we will put in place for winter 2016/17

- Day of Care Audit Ninewells and Stracathro 1 September 2016
- Discharge hub PRI to be developed – plus discharge to assess model Health and Social Care Partnerships will ensure that discharge planning is coordinated across agencies
- Ambulatory care model to be tested and developed for PRI ward 4 medial admission unit
- Learning implemented from deep dive into PRI readmissions
- Improvement programme to improve pathways of care across hospital and community settings for Perth. This will include development of an Integrated Intermediate Care Model, Discharge to Assess and Assess to Admit models, workshops with SAS in PRI and NW to establish redesign for flows and am discharge
- Criteria-led Discharge (CLD) to being piloted on medical and surgical wards
- TAS/DOSA model will implemented at PRI
- Partnerships have developed plans to address expected levels of demand over the winter period including additional care at home staff, additional commissioned hours, temporary care home capacity and tests of change for home care in reach and service retention
- Seven day AHP support across orthopaedics and vascular surgery PRI and Ninewells
- Advanced Nurse Practitioner (ANP) support across the surgical floor in Ninewells, coordinating junior doctor activities.
- Supported discharge input for surgery and orthopaedics in PRI and Ninewells.
- Prescribing pharmacist aligned to ward 7 and 8 in PRI from October to March
- Development of a frailty and deteriorating patient pathway across NHS Tayside

<u>Essential Action 4</u>

Medical and surgical processes arranged to improve patient flow through the unscheduled care pathway; hospital departments should be enabled to rapidly stream patients to appropriate and timely assessment in ED, and processes should be in place to pull patients from the ED to assessment/receiving areas where short-stay assessment or admission is necessary. Access to diagnostics and specialist opinion should be available when required, with workforce and job planning ensuring resources match demand. Delays to care

[5] www.isdscotland.org/Health-Topics/Health-and-Social.../**SPARRA**/

pathways and in discharges from wards can be minimised through daily decision-making reviews and multi-disciplinary rounds focusing on facilitating discharge when patients are deemed medically and therapeutically fit. This process can be supported by criteria-led discharge procedures spanning seven days.

What is in place?

- Acute care standards audit across whole system by 27/07/16 to ensure prompt access to senior decision maker at every stage of patient journey in line with acute quality standards
- AMU model with streaming of patients and ambulatory care model In Ninewells
- Twice daily review by a consultant in acute assessment areas ensures active care management
- Daily decision-making reviews and multi-disciplinary rounds focusing on facilitating discharge when patients are deemed medically and therapeutically fit
- Visits to Fife discharge hub. PRI team also visit Dundee discharge hub
- Daily MDT board rounds in place with further MDT meetings planned throughout the week to agree Planned Date of Discharges (PDDs)

What we will put in place winter 2016/17

- Reviewing pathways through Clinical Investigation Unit in Ninewells to avoid unnecessary elective admission to the inpatient wards and AMU
- Criteria led discharges test of change in surgical and medical specialties
- Plans to have a dedicated stroke rehabilitation ward in Royal Victoria Hospital which should improve flow and pathways of patients downstream
- SAS / Voluntary Organisation joint led patient transport workshop Ninewells site and PRI site to support learning and improve appropriate use of transport and non-NHS alternatives
- Test ambulatory care model and streaming in PRI ward 4

<u>Essential Action 5</u>

Seven day services appropriately targeted to reduce variation in weekend and out of hours working, and; variations in access to assessment, diagnostic and support services during. Weekends and other out-of-hours periods should be reduced. Where possible, emergency care cases should be shifted to urgent care, length of stay should be reduced and rates of weekend and early-day discharges (when safe to do so) should be improved. It will also be necessary to “flex” services such as pharmacy; cleaning and transport to match work being undertaken in other seven-day services

What is in place?

- OOH GP led service in place seven days a week
- Improvement profiles/requirements for pro-rata mid-week rates of emergency admission/discharge at weekends and public holidays agreed
- Every ward has a daily consultant led ward round to enable discharge seven days a week
- Unscheduled care standards audit conducted to review of clinical support services such as diagnostic, pharmacy to ensure adequate across seven days
- “Golden Weekend” exercise in place over a weekend and public holiday to identify potential improvements

- Professional to professional call in place in seven days a week ED and AMU to manage surges in GP post home visit referral calls and SAS professionals to ensure appropriate signposting and guidance for patients not requiring admission
- ED support advice and guidance for PRI A&E at & Minor Injury Units at the weekend

What we will put in place winter 2016/17

- Develop improvement profiles/requirements for the following seven day services:
    - AHP (additional hours available for AHP staff in each locality if required)
    - Diagnostics
    - Pharmacy (previous review in Angus identified no additional demand in winter months)
    - OOH
    - SAS
    - Expedited outpatient radiology
    - GP / MfE cover over festive period for community hospitals
- Criteria led discharge to be explored for top five unscheduled pathways
- Non clinical support to be integrated into discharge hub PRI
- Recruitment of weekend flow coordinator role to supplement the OOH coordinator to ensure non-clinical support services including cleaning and portering provide optimal care across seven days to avoid /facilitate admission and facilitate timely discharge
- SAS direct referrals test of change planned

.

Essential Action 6

Ensuring patients are optimally cared for in their own homes or a homely setting. To sustain unscheduled care, it is important to support patients to manage their long-term conditions and live (and die) well at home. Close working with integrated joint boards and other community-led improvement programmes will enhance this approach.

What is in place?

- Local “Know who to turn to” campaigns, supported by local redirection policies in ED with “z” cards to educate patients about the most appropriate professional to meet their needs
- Anticipatory care plans in place to support decisions about optimal care and ensure rapid assessment is available when an unscheduled care episode occurs
- A directory of services and alternatives to admissions is published on the NHS Tayside website covering primary and community services and also third and independent sector social care provision
- Enhanced Community Support (ECS) continues to be successfully delivered within South West and South East localities. This is very much embedded in practice there and Dundee GP clusters in order to manage patients in their own home preventing unnecessary hospital attendance and admission. Perth & Kinross have rolled out ECS into Perth City and Strathmore localities
- Strata tool in place which builds the linkage of patient information systems between the community and acute services to enable community care teams to identify patient needs and anticipate future care needs in order to avoid unnecessary admission to hospital and maximise anticipatory care in the community
- Frailty model in place in Ninewells including medicine for the elderly consultant in place supporting prevention of admission
- Full utilisation of capacity in community hospital and step down/up beds and Intermediate care models

- Professional to professional call process in place AMU at Ninewells Hospital
- The 'Help to live at home' programme in Angus continues to develop our home care local market for private and third party providers of care with the aim to increase efficiency and capacity of home care provision
- Increased technology enabled care options where outcomes for individuals in home or within community settings are improved through the application of technology as an integral part of quality cost-effective care and support. This includes, but is not limited to the use of telecare, telehealth, video conferencing (VC) and mobile health and well-being
- A wellbeing bid has been submitted to Scottish Government to be a test site for the implementation of "Buurtzorg" [6]methods within Angus
- Review of care at home provision in Perth & Kinross
- Care at Home Service, Home Care and Resource Matching Unit: - The Resource Matching Unit is now established and along with the increase resource provision has increased capacity and efficiency of the care at home service. This has contributed to the reduction in number of delays due to patients awaiting a care package
- Additional care home placements to generate additional capacity within Dundee
- Dundee smart flat and step down housing service: - demonstration flat for step down and rehabilitation resource which was launched in June 2016. In addition to this, step down housing resources have been developed as a partnership with Housing Associations. Already the step down resource has contributed to people being discharged when they are ready and contributes to our strategic intention to increase availability of step down resources
- Discharge Management Team and Integrated Discharge Hub in Dundee– The increased AHP and nursing input into the discharge team has increased its capacity to coordinate discharges and contribute to the development of an Integrated Health and Social Care Discharge Hub. An integrated social work and Health Discharge Hub was implemented on 3 December 2015. This Hub has established a single route for referrals, reduced duplication between social work and health teams and established a shared ethos on person centered discharge planning within a multi-disciplinary team approach
- Increased Social Work Occupational Therapy Service and Equipment. A single shared pathway across health for accessing equipment and adaptations was implemented during 2015 in Dundee. This has greatly reduced duplication, reduced delays due to awaiting equipment/ adaptations and with the increased Social Work Occupational Therapy resource, has meant that discharge assessments are completed within 24 hours of request. Equipment is then delivered within 24 hours of an equipment prescription
- Additional hours to the Mental Health Outreach (MHO) Service in Dundee have significantly increased capacity of the MHO Service to respond to requests for guardianship reports. This has resulted in a timely completion of reports and reduction in waiting time for an MHO
- Additional funding to the community nursing service in Dundee has increased capacity of the service to improve communication and person centered care at point of discharge where patients require ongoing support from the service
- Enhanced Community Support to seven GP Practices Perth City and Strathmore area

[6] academy.alliance-**scotland**.org.uk/tag/**buurtzorg**

What we will put in place winter 2016/17?

- Roll out of Enhanced Community Support (ECS) to Angus North East Locality
- Review Nursing/Residential Sector short stay impact of Enhanced Community Support in Angus
- Continue to roll out ECS across Perth City and North Perthshire
- Increase step up/down bed provision in Angus
- Home care protocol/policy in place Perth & Kinross
- Negotiate additional Intermediate Care Beds in Perth City
- Develop our Home Care market in Angus incentivising private providers in harder to reach areas
- Proactively reduce non-complex (excluding Code 9) patient delays for Angus residents in Ninewells by co-ordinating available health and social care capacity
- In partnership with the Third Sector and Social Enterprise Care in Angus work in partnership with the aim to provide increased befriending, volunteer driving and home support
- Joint Perth & Kinross health improvement plans in place to support more placement locally
- Discharge to assess models utilised at every opportunity to prevent unnecessary admissions with test of change in PRI ward 4
- Optimise information sharing and communications with continued development of STRATA[7] phase 3 for proactive referrals to Health and social care
- Test discharge hub and discharge to asses model PRI
- Review medical model of care for community hospitals
- Explore Integrated Community Hubs in localities Perth & Kinross
- Recruitment and retention drive for GP practices- including GP modular posts - for 'First Five' (supporting newly qualified GPs) and Last Five (before retirement) GPs to leadership posts offering new types of employment.
- Review of the community provision for patients requiring Psychiatry of Old Age (POA) to enhance the available community support and support care home provides to care for residents in house rather than seeking admission
- Further develop awareness and use of anticipatory care plans for all adults where a plan would be of benefit.
- Promote power of attorney through local campaigns as a means of increasing number of power of attorneys so that adults are not waiting in hospital settings for decisions about their care upon discharge.
- In Dundee establish and implement a discharge management learning framework and learning networks as a means of promoting and enabling consistency in practice and ensuring effective person centred communication during transition between hospital and home
- Develop an 'early indicator of deteriorating health and well-being tool', for use by front line social care staff in to reduce the instances of hospital admissions, increase the use of preventative interventions, and assist people to look after their health and well-being
- Support more people to be assessed at home or a homely setting rather than in hospital by completing and evaluating the 'Moving Assessment into the Community' project for older people in Dundee.

[7] www.**nhs**taysidecdn.scot.**nhs**.uk/**NHS**TaysideWeb/idcplg

Unscheduled/ Elective Care Preparedness Unscheduled/ Elective Care Preparedness – Resilience planning

This section focuses on our preparation and plans for resilience and business continuity in the event of any outbreak or norovirus or influenza or respiratory infections. The section details our plans for communication and services that are provide to support the public over the winter period (OOH) to know who to turn or and where and how to access services when GP services are closed.

Effective communication

NHS Tayside has robust communications plans with the public, patients and staff that make use of all available mediums, including social media, in order that key messages are accurate and consistent.

- NHS Tayside website provides all festive proviso information for staff. We use the Met Office National Severe Weather Warning System to provide information on the localised impact of severe weather events. Action cards in place
- NHS Tayside proactively links with the 'Be Healthwise This Winter' campaign, tailoring the national key messages for the local situation and a local audience and releasing media releases and social media messages throughout the winter period. The "Be Healthwise This Winter" and "Ready Scotland" campaigns are featured on the NHS Tayside website using the digital assets provided by the national campaigns. We will also run a norovirus campaign with many messages featuring over the winter months. The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and militate against the consequences from a range of risks and emergencies
- Social media is the best channel for instant updates to information and will be used extensively, along with media releases, website updates, radio updates and sharing of messages with local partners for onward distribution
- Out-of-hours service information is published to inform the public how that will work and how that complements the national communications being led by NHS 24
- The Corporate Communications Team updates the NHS Tayside website with weather and travel information as necessary and promotes Ready Scotland on the front page of its website
- Public communications strategy to raise awareness of access arrangements over the festive period and includes advertising campaign in local media with GP, pharmacy and Minor Injury Unit opening hours. Supported by regular social media and website posts to share information and signpost to available services
- NHS Board communications regarding bed pressures and norovirus ward closures are optimal and everyone will be kept up to date in real time
- The Communications Department has a proactive approach to Ward closures to norovirus outbreaks and alerts all media outlets, updates social media and NHS Tayside website to every incident as soon as alert received from Infection Control Department. Clear key messages are deployed including details of any visiting restrictions.
- The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the 'Stay at Home Campaign' message.

- NHS Tayside Communications actively promotes Norovirus publicity materials and national campaign assets and shares widely through social media channels, including Face book and Twitter and local media
- Templates with key contacts and service levels are established - these will be further developed and shared across the health and care system in 2015/16
- Unscheduled Care Programme Board will support the development of whole system escalation plans which will be in place for winter 2016/17
- Daily huddles will be a key focus for identification and management of system pressure and will include representatives from across the health and social care system and stretch into community hospitals

Out-of-Hours Preparedness

NHS Tayside has out-of-hours Pandemic Flu Action Plan updated on 25 August 2016. The plan outlines the actions to be taken by Tayside OOH service from the time World Health Organisation Phase five Pandemic risk is declared. These actions have been planned within the framework of the primary care pandemic group.

- Established OOH flu management group in place led by OOH Head of Service and Medical Director
- NHS24 prediction data not available until late October but where this and OOH service data differ, capacity will be planned around the greater of the two.
- Resource availability over an eight day period confirmed for all Primary Care Emergency Centre (PCEC) - Arbroath Infirmary, Kings Cross, Perth Royal Infirmary including GP shifts, drives, nursing staff etc
- By October agree the level of triage December 2016 – April 2017 including Christmas/New Year. Christmas/New Year Triage shifts will be added to rota once other shifts are filled
- Annual leave applications from 22 December 2016 to 5 January 2017 will be considered on an individual basis but are unlikely to be compatible with maintaining full staff availability. All management team will be either on duty or on call over the festive period
- January to March as part of the Winter Plan there will be an extra car, driver and GP available because of the extra demand
- The management team will monitor activity weekly and decide on any extra capacity required
- 10 cars will be available for use over the two festive holiday weekends to assist with the expected level of demand of home visits at peak times. (Three more than base level)
- Increase GP Triage to two GPs on 27 and 28 December 2016 and 2 and 3 January 2017
- A number of initiatives have been put in place to reduce demand including the following**:** Ensure that GP OOH Rotas are on the Taycare System for both the holiday periods All practices are contacted pre festive period requesting that they keep patient special notes up to date
- Demand Management - resources will be targeted around priorities across Tayside by the team leaders and dispatchers patients will be offered transportation to other PCECs
- Communications to the public adverts in all local Tayside newspapers week beginning Monday 19 December 2016 Communications and Engagement Plan to be developed by the Communications & Engagement Group
- Out-of-hours service staff will email week beginning 12 December a briefing newsletter to all staff outlining the arrangements for the festive period and winter period January to March including extra staffing and escalation plans and

communication arrangements with NHS 24 and other agencies both internal and external

- Discussion to take place with SAS with regard to effective and efficient use of the SAS paramedic service in North West Perthshire and to improve communication generally with SAS. Clarification of coverage over the festive period to be sought to ensure the OOH service is supported. Details of our festive and winter plans will be shared
- We have worked closely throughout the year with NHS 24 meeting with NHS 24 account manager. Agreement around escalation process and local contingency arrangements for local centres. Agreement reached around the sharing of information between NHS 24 and OOH
- OOH escalation process has been passed to NHS 24
- Staffing contingencies in place including a list of GPs in outlying areas, who would be willing to be contacted if there were severe weather conditions and areas were cut off. This is a part of the Scottish Government Transformation of Urgent Care testing process
- Contact arrangements are in place for a clear for reporting vehicle faults and breakdowns over the public holiday period and emergency OOH contact list available to the management team in case of severe weather and routes are blocked
- The plan will be to fill to all available to work the planned rotas. There are difficulties recruiting GPs to fill shifts generally though an enhanced payment is offered throughout the festive period
- A process has been developed to ensure effective and efficient use of the SAS paramedic service.
- There is an evening service provided in Dundee, Perthshire and Angus. Each work differently. A list of names and contact details are be given to the Hub for each area.
- The evening and overnight district nursing service is now based in Dundee in Kings Cross and both formal and informal communication is improved with case discussions and working together on complex cases
- Regular meetings in place with ED to liaise with ED consultants regarding winter plans
- A list of community pharmacists that will be open over the festive period, in addition to the rota, will be published. Contractor lists are available on the intranet and are updated every Saturday
- All dental calls are now dealt with by NHS 24 and dental OOH
- Links with social work departments across Tayside to identify what/when/where services will be available over the festive and winter period through the Tayside capacity planning structure
- IT and telephony - the OOH service uses Adastra which is supported by Advanced. The OOH service has 24/7 support from these suppliers. IT/telephone contingency – the OOH service has back up manual systems in the event of IT/telephony failure
- The OOH service has a process whereby nursing homes are able to contact the OOH service using their ‘Fast Track’ number instead of having to go through NHS 24. Designated GPs are available to call the nursing homes back regarding specific cases
- NHS Tayside has an incident management system (Datix), which is used to record, analyse and report incidents. All OOH GPs have been issued with an aide-memoir to have access to and use of the Datix system and all staff are encouraged to record adverse events on Datix. In addition to formal reviews, the service has weekly slots available for SEAs (GPs value these times for personal development and appraisal purposes) and three monthly evening meetings to reflect on SEAs and improvements to be made where applicable

Preparing for and Implementing Norovirus Outbreak Control Measures

NHS Tayside has a comprehensive plan in the event of any outbreak which is robust and tested

- Infection Prevention and Control Teams (IPCTs) will be required to confirm they have read the revised guidance - HPS Norovirus Outbreak Guidance. The HPT will update local guidance / resources and circulate alongside nationally produced materials advising care homes on timely preparation, identification and management of norovirus cases and outbreaks was refreshed in September 2016
- IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. NHS Tayside HPT routinely works and communicates closely with IPCT through established phone and email pathways, providing confidence that relevant information will promptly be shared
- HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff; with all up to date national & local guidance is accessed via the norovirus section on the infection control site of Staffnet
- Organisational awareness raised by Norovirus Vital Signs which will be issued October 2016.
- Daily hospital level huddles held at Ninewells and Perth Royal Infirmary. Communication includes engagement via the NHS Tayside Communication Team to alert and inform relevant stakeholders e.g. patients, visitors, staff and the public via local media, pop up banners, etc.
- There is direct communication with Dundee University Medical School to minimise any impact on teaching
- Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks. This is included within standard procedures
- On receipt of national norovirus situation, information received weekly from HPS is distributed by Infection Control General Manager to Executive and Director generic email distribution list
- Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge. This is incorporated into ongoing communication/education throughout the year
- Microbiologist on call 24/7. To provide adequate IPCT cover across the whole of the festive holiday period and ICNs rostered either onsite/on call over festive period
- Infection Control Team alerted to issues via the iModus Communication System and involved in capacity and flow discussions as part of the hospital wide daily safety huddles where relevant to respond to rapidly changing norovirus situations, e.g. the closure of multiple wards over a couple of days
- There is a direct line of communication and collaborative working between infection control and support services regarding forward planning/resource allocation of domestic services, laundering services including curtain changing staff to support additional cleaning and readiness for ward/bay re opening
- A generic infection control email distribution list is available to support current communication channels to optimise resources and response to the rapidly changing norovirus situation
- Publicity materials to spread key messages around norovirus and support the ‘Stay at Home Campaign’ message will be widely distributed throughout NHS Tayside

Seasonal Flu, Staff Protection and Outbreak Resourcing

It is important that staff are vaccinated against seasonal flu, particularly front-line staff and those working in areas where patients might be at greater risk (paediatric, oncology, maternity, care of elderly, haematology, critical care facilities). The aim is to vaccinate 50% of front line staff.

- Robust communication pathways between IPCT and Health Protection Team (HPT) are well-established, including direct phone/page numbers, continuously staffed admin/call-handling provisions, generic team email addresses, and OOH arrangements
- Achieving uptake targets remains a challenge, including among clinical staff. Planning for delivery in 2016/17 has looked at increasing the options to increase uptake especially in these staff groups. Plans to further streamline data capture and analysis, to ascertain greater detail on uptake in specific clinical areas/categories, are also in progress
- All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in Chief Medical Officer (CMO) Letter (2014) 12 clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations
- Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible
- As in previous years, peer vaccinators will work across multiple shift times in areas with high risk patients. Occupational health services additionally offer drop-in appointments at major healthcare sites, and community pharmacies are funded to vaccinate any NHS Tayside employee
- The winter plan takes into account the predicted surge of flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period
- The Health Protection Team (HPT) will implement its established incident or major incident management plans and procedures as and when warranted – co-ordinated with Board level resilience responses
- Processes are in place for circulation of guidance from CMO and other relevant sources on use of antivirals to clinical professionals
- Close liaison between Public Health Consultants in Health Protection and Pharmacy, and with Ninewells Pharmacy, will ensure timely supply of antivirals and/or vaccine for targeted administration as required
- The HPT receives the regular flu activity updates from Health Protection Scotland, and these are monitored by a designated consultant and nurse specialists. The team is well-practised at using established communication pathways, both ad-hoc (e.g. email distribution lists) and routine (e.g. newsletters), to promptly forward and provide summaries of key updates and advice to clinical colleagues
- Adequate resources are in place to manage potential outbreaks of seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. Resources answering these requirements include the NHS Tayside Pandemic Influenza Preparedness and Response Plan, Health Protection (Major) Incident Plan, infection prevention and control policies, and NHS Tayside's Major Incident procedures and strategic response plan

Respiratory Pathway

- Partners in NHS Tayside have developed a strong respiratory pathway over recent years
- Local guidance and information is in place to promote self-management and supported self-management
- The respiratory pathway links with anticipatory care plans and telehealth
- Specialist respiratory service is in place
- Respiratory conditions are recognised as a significant factor in additional winter pressures and were a particular feature of 2014/15
- During 2015/16 respiratory pathway work is being further enhanced through a multi-disciplinary approach developed using integrated care fund resources
- Promote range of respiratory guidelines and public information leaflets
- Communicate self-management messages as part of communication plan

Conclusion

This plan provides a comprehensive and detailed plan of all the action NHS Tayside will put in place to support winter planning and resilience. This plan is dynamic and will be added to as a working document.

Measures

1. **Business continuity plans tested with partners.**
Outcome: • The board has fully tested business continuity management arrangements / plans in place to manage and mitigate against key disruptive risks including the impact of severe weather
Local indicator(s): • progress against any actions from the testing of business continuity plans

2. **Escalation plans tested with partners.**
Outcome: • Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes
Local indicator(s): • attendance profile by day of week and time of day managed against available capacity • locally identified indicators of pressure (i.e.) % occupancy of ED, utilisation of trolley/cubicle, % of patients waiting for admission over two, four hours • all indicators should be locally agreed and monitored

3. **Safe & effective admission / discharge continues in the lead-up to and over the festive period and also in to January.**
Outcomes: • Emergency and elective patients are safely and effectively admitted and discharged over the Christmas - New Year holiday period • The numbers of patients receiving elective treatment reduces and the risk of boarding medical patients in surgical wards is minimise • Patients do not have unnecessary stays in hospital; hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January
Local indicator(s): • daily and cumulative balance of admissions / discharges over the festive period • levels of boarding medical patients in surgical wards • delayed discharge • community hospital bed occupancy • number of Social Work assessments including variances from planned levels.

4. Strategies for additional surge capacity across Health & Social Care Services
Outcome: • The risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised. The staffing plans for additional surge capacity across health and social care services is agreed in October. The planned dates for the introduction of additional acute, community and social work capacity are agreed and that capacity is operational before the expected surge period. It is essential that additional capacity is developed alongside appropriate arrangements to create a safe and person centred environment
Local indicator(s): • planned additional capacity and planned dates of introduction • planned number of additional staffed medical beds for winter by site and the planned date of introduction of these beds • planned number of additional intermediate beds in the community and the planned date of introduction of these beds • levels of boarding • planned number of extra care packages • planned number of extra home night sitting services • planned number of extra next day GP and hospital appointments

5. Whole system activity plans for winter: post-festive surge / respiratory pathway.
Outcome: • The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. Hospital models will include flows between front doors, receiving units, and downstream wards.
Local indicator(s): • daily number of cancelled elective procedures; • daily number of elective and emergency admissions and discharges; • number of respiratory admissions and variation from plan.

6. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance
Outcome: • NHS Boards have, and use, a range of analysis to effectively plan for and monitor winter capacity, activity, pressures and performance at board and site levels.
Local indicator(s) : • Agreed and resourced analytical plans for winter analysis.

7. Workforce capacity plans & rotas for winter / festive period agreed by October.
Outcomes: • Rotas and workforce capacity plans for all disciplines are agreed for the winter (and particularly the four day festive holiday) period by October to underpin safe and effective admission and discharge of emergency and elective patients. This should encompass all relevant health and social care services. • Maintain discharges at normal levels over the two four day festive holiday periods
Local indicator(s): • workforce capacity plans and rotas for winter / festive period agreed by October • effective local escalation of any deviation from plan and actions to address these • extra capacity scheduled for the 'return to work' days after the four day festive break factored into annual leave management arrangements • number of discharges on each of the four day festive holiday periods compared to number of normal daily discharges

8. Discharges at weekends & Public holidays
Outcome: Patients are discharged at weekends and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital. Medical and Nurse Directors provide monthly report on weekend (pre-noon) discharge rate progress and performance.
Local indicator(s): • % of discharges that are criteria led on weekend and bank holidays; • daily number of elective and emergency admissions and discharges.

9. The risk of patients being delayed on their pathway is minimised.
Outcome: • Patients receive timely assessments in ED, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge. Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital. There is early engagement with SAS for ambulance discharge and transfer. Medical and Nurse Directors provide monthly report on ward by ward, in/out balance, daily discharge progress and performance
Local indicator(s): • distributions of attendances / admissions • distribution of time to assessment • distribution of time between decision to transfer/discharge and actual time • % of discharges before noon • % of discharges through discharge lounge • % of discharges that are criteria led • levels of boarding medical patients in surgical wards

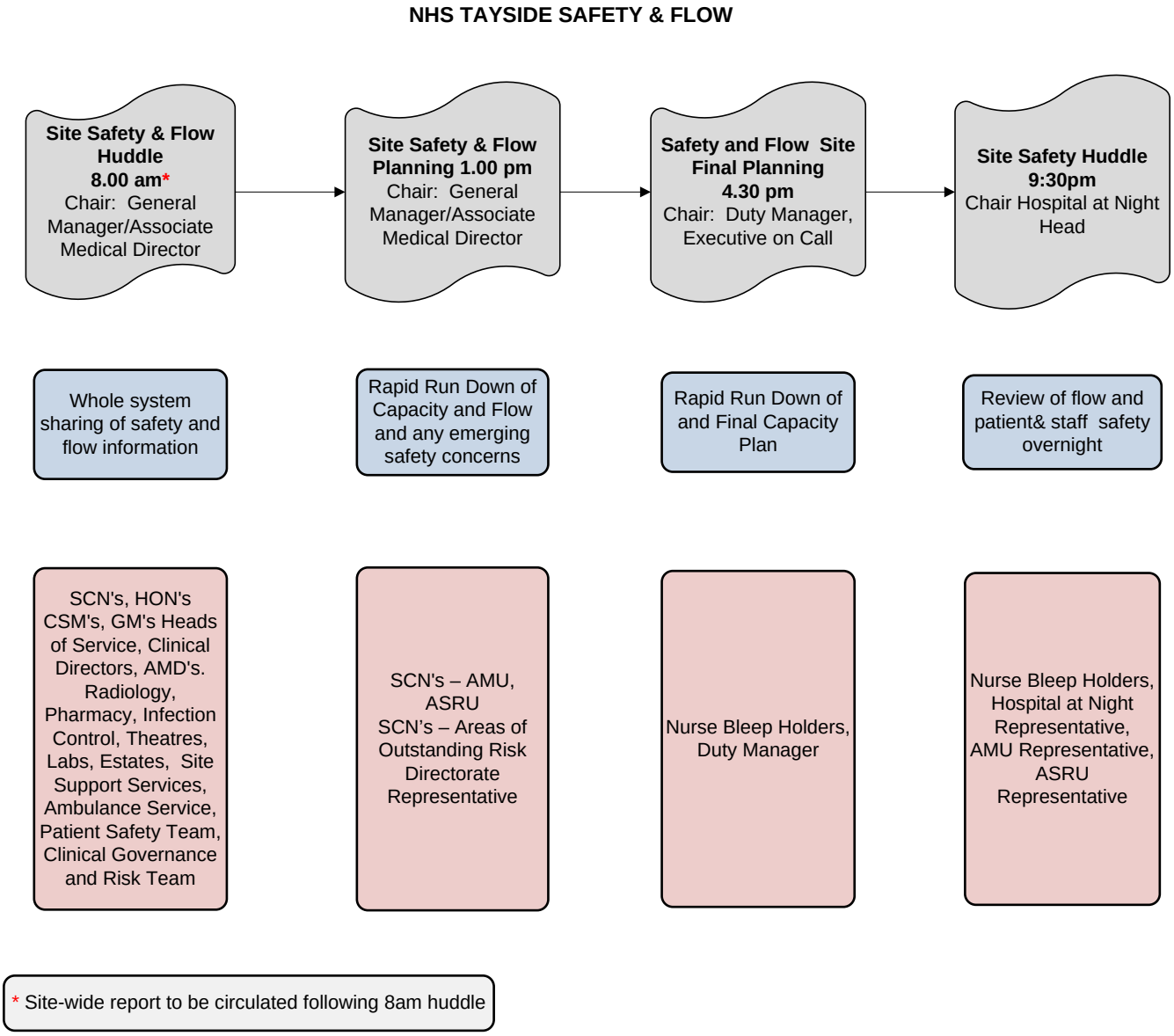
10. Communication plans
Outcome: • The public and patients are kept informed of winter pressures, their impact on services and the actions being taken
Local indicator(s) : • daily record of communications activity • early and wide promotion of winter plan

11. Preparing effectively for norovirus.
Outcome: The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised through the effective implementation of the HPS Norovirus Outbreak Guidance (2016/17).
Local indicator(s): • number of wards closed to norovirus • application of HPS norovirus guidance

12. Delivering seasonal flu vaccination to public and staff.
Outcome: • CMO uptake targets for seasonal flu vaccination for those aged 65 and above, at risk groups and front line staff are delivered in accordance with CMO Guidance
Local indicator(s): • % uptake for those aged 65+ and ‘at risk’ groups • % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.

Appendix 1

Safety and Flow Huddle Diagram



Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item 8.1

BOARD99/2016
Tayside NHS Board
27 October 2016

HEALTHCARE ASSOCIATED INFECTION (HAI) CONTROL IN TAYSIDE FOR JULY AND AUGUST 2016

1. SITUATION AND BACKGROUND

Infections contracted while receiving healthcare are a significant cause of ill health. Members of the public reasonably expect that all practicable measures are being taken to reduce the opportunity for acquiring an infection as a result of their treatment and care.

HAI is a priority patient safety issue for both the SGHD and NHS Tayside, being one of the most important events that can adversely impact on patients when they receive care

Dr Gabby Phillips is the Lead Doctor Infection Control and Dawn Weir is the General Manager Infection Control. They are the lead officers for the HAI Strategy and annual programme of work.

Dr Busi Mooka is the lead for antimicrobial prescribing.

Attached to this report is the summary position for July and August 2016.

2. ASSESSMENT

To provide an update on progress with Healthcare Associated Infection (HAI) in Tayside using the standard reporting template as mandated by the Scottish Government Health Directorate (SGHD).

NHS Tayside

i.) is currently above the HEAT target for SABs.
ii.) is currently above CDI HEAT target

3. RECOMMENDATIONS

For information

4. REPORT SIGN OFF

Ms Lesley McLay, Chief Executive

Dr G Phillips
Lead Infection Control Doctor

Ms L McLay
Chief Executive

Dr B Mooka
Consultant Physician, Infection Unit/Lead Clinician for the AMT

October 2016

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1– Board Wide Issues

This section of the HAIRT covers Board wide infection prevention and control activity and actions. For reports on individual hospitals, please refer to the 'Healthcare Associated Infection Report Cards' in Section 2.

A report card summarising Board wide statistics can be found at the end of section 1

Key Healthcare Associated Infection Headlines for July and August 2016

- CDI rate is above target but relatively stable
- NHS Tayside is in line with the 3 antibiotic prescribing targets that support the CDI HEAT target, compliance with the target for surgical prophylaxis is showing a high level of reliability.
- SAB rate is above target and increasing: please see Appendix 3.

Staphylococcus aureus (including MRSA)

Staphylococcus aureus is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. The most common form of this is Meticillin Sensitive *Staphylococcus Aureus* (MSSA), but the more well known is MRSA (Meticillin Resistant *Staphylococcus Aureus*), which is a specific type of the organism which is resistant to certain antibiotics and is therefore more difficult to treat. More information on these organisms can be found at:

Staphylococcus aureus : http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346

MRSA:http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252

NHS Boards carry out surveillance of *Staphylococcus aureus* blood stream infections, known as bacteraemias. These are a serious form of infection and there is a national target to reduce them. The number of patients with MSSA and MRSA bacteraemias for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Staphylococcus aureus* bacteraemias can be found at:

http://www.hps.scot.nhs.uk/haiic/sshaip/publicationsdetail.aspx?id=30248

Clostridium difficile

Clostridium difficile is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. More information can be found at:

http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx

NHS Boards carry out surveillance of *Clostridium difficile* infections (CDI), and there is a national target to reduce these. The number of patients with CDI for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Clostridium difficile* infections can be found at:

http://www.hps.scot.nhs.uk/haiic/sshaip/ssdetail.aspx?id=277

Hand Hygiene (HH)

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections. More information on the importance of good hand hygiene can be found at:

http://www.washyourhandsofthem.com/

NHS Boards monitor hand hygiene and ensure a zero tolerance approach to non compliance. The hand hygiene compliance score for the Board can be found at the end of section 1. Information on national hand hygiene monitoring can be found at:

http://www.hps.scot.nhs.uk/haiic/ic/nationalhandhygienecampaign.aspx

Cleaning and the Healthcare Environment

Keeping the healthcare environment clean is essential to prevent the spread of infections. NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.The cleaning compliance score for the Board can be found at the end of section 1 and for each hospital in section 2. Information on national cleanliness compliance monitoring can be found at:

http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Healthcare environment standards are also independently inspected by the Healthcare Environment Inspectorate. More details can be found at:

http://www.nhshealthquality.org/nhsqis/6710.140.1366.html

The Infection Control team undertakes two all inpatient site audits per year. This is a high level audit that provides an independent assessment of the local audits that are performed on a regular and frequent basis by every ward and department.

Thirteen infection control domains are audited and the requirement is that hand hygiene is deemed compliant if above 90% and compliance of 80% is needed for all other domains (in NW and PRI) – other sites have a higher target for compliance. Domains audited include sharps management, ward fridge temperature recording, adherence to cleaning schedules, safe linen management, equipment cleanliness, evidence that the area is undertaking local audit, correct use of personal protective equipment (PPE), implementation of PVC bundles, water management records, etc. This was last undertaken in July 2016.

It is a large and complex audit to summarise as there may be variations in the domains across and between sites. On this occasion there were, generally, improvements seen in the domains of documentation of water outlet flushing where required, correct use of PPE (e.g. gloves and aprons), display of up to date infection data and the availability of patient information for specific infections. There was evidence that wards were undertaking their own local audits in the main. Results from the domains such as sharps management, hand hygiene, use of cleaning schedules and equipment cleanliness demonstrated that improvements were required in general across several sites.

The results were sent to senior staff within the Directorates so that the findings could be discussed at relevant fora and action plans developed around areas where improvements were required. At the time of writing these are in the process of being returned to Infection Control and Management. These domains are those that external agencies such as Health Improvement Scotland and others would examine as part of the implementation of the basic Standard Infection Control Precautions.

Outbreaks

This section should give details on any outbreaks that have taken place in the Board since the last report, or a brief note confirming that none have taken place. Where there has been an outbreak then for most organisms as a minimum this section should state when it was declared, number of patients affected, number of deaths (if any), actions being taken to bring the outbreak under control and whether this was reported to the Scottish Government. For outbreaks of norovirus a more general outline of the outbreak may be more appropriate.

Suspected pertussis cases continued to lead to contact tracing exercises. No secondary cases in patients or staff were detected.

Several cases of *St aureus* (not MRSA) with an unusual strain type were found clustering in NHS Tayside in 2015/2016. Possible links to skin conditions are being investigated and infection control audits were done in all dermatology areas. Some remedial issues around environment and equipment cleaning were addressed. There have been no new cases in over 6 weeks at the time of writing.

A medical ward was closed for Influenza A for 7 days.

Other HAI Related Activity - See Appendices as below		Page(s)
Appendix 1	MRSA	10
Appendix 2	Vancomycin-resistant Enterococcus (VRE)	11
Appendix 3	SAB Data	11-12
Appendix 4	CDI Data	12
Appendix 5	ESBLs and other multi-drug resistant Gram-negative bacteria	12-13
Appendix 6	Antimicrobial Prescribing data	13-15
Appendix 7	Surgical Site Infection (SSI) data	15
Appendix 8	Hot Topics / Horizon Scanning	16
Appendix 9	HAI and Medical Certificate of Death	16
Appendix 10	Status of HEI Action Plans	17
Appendix 11	Glossary	18

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information, for each acute hospital and key community hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections *(*also broken down into MSSA and MRSA) and *Clostridium difficile* infections, as well as hand hygiene and cleaning compliance. In addition, there is a single report card which covers all community hospitals [which do not have individual cards], and a report which covers infections identified as having been contracted from outwith hospital. The information in the report cards is provisional local data, and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. The national reports are official statistics which undergo rigorous validation, which means final national figures may differ from those reported here. However, these reports aim to provide more detailed and up to date information on HAI activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers
Clostridium difficile infections (CDI) and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month. Staphylococcus aureus bacteraemia (SAB) cases are further broken down into Meticillin Sensitive Staphylococcus aureus (MSSA) and Meticillin Resistant Staphylococcus aureus (MRSA). More information on these organisms can be found on the NHS24 website:

Clostridium difficile: **http://www.nhs24.com/content/default.asp?page=s5_4&articleID=2139&sectionID=1**

Staphylococcus aureus: http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346

MRSA: http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252&sectionID=1

For each hospital the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card.

Targets
There are national targets associated with reductions in C.*difficile* and SABs. More information on these can be found on the Scotland Performs website:

http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance

Understanding the Report Cards – Hand Hygiene Compliance
Monthly audits are carried out by nursing teams in a wide range of clinical settings across NHS Tayside. The compliance figure from this date onwards represents the score derived from measuring the combined compliance of opportunity and technique. This means that we start from a new baseline.

Understanding the Report Cards – Cleaning Compliance
Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website:
http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Understanding the Report Cards – *'Out of Hospital Infections'*
Clostridium difficile infections and *Staphylococcus aureus (*including MRSA*) bacteraemia* cases are all associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes and. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital.

NHS TAYSIDE BOARD REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
MRSA	2	2	0	0	0	1	0	1	0	1	0	0
MSSA	11	11	9	14	12	18	13	11	5	12	12	14
Total SABs	13	13	9	14	12	19	13	12	5	13	12	14

* One source outwith Tayside
Within the natural variation parameters

Clostridium difficile infection monthly case numbers

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Ages 15-64	7	6	3	4	1	3	4	1	5	6	2	3
Ages 65 plus	6	9	10	9	9	5	7	7	9	8	11	7
Total CDI	13	15	13	13	10	8	11	8	14	14	13	10

* 1 case indeterminate as to which hospital to allocate against, counted in Tayside total only.
Within natural variation parameters

See Appendix 3 for related SAB information and Appendix 4 for CDI information

Hand Hygiene (HH) Monitoring Compliance (%)

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Medical	92	94	97	95	91	90	92	89	94	92	98	92
Nurse	99	97	97	97	98	96	97	97	98	98	96	98
AHP	100	99	95	95	98	93	98	94	96	88	99	94
Ancillary	89	93	93	86	98	81	84	87	95	90	88	91
Combined	95	96	95	93	96	90	93	92	96	92	95	94

Support from the Infection control team is provided to those areas where results are suboptimal. The figure now reflects the combined opportunity and technique score. Variation is noted as different sites are audited on each occasion.

Cleaning Compliance (%)

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Board Total	94	95	95	95	95	94	94	94	95	94	94	95

Estates Monitoring Compliance (%)

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Board Total	96	95	95	96	95	96	97	95	96	96	95	95

NHS TAYSIDE

NINEWELLS HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
MRSA	1	0	0	0	0	1	0	0	0	1	0	0
MSSA	4	4	6	4	4	8	4	1	2	2	4	5
Total SABs*	5	4	6	4	4	9	4	1	2	3	4	5

Clostridium difficile infection monthly case numbers

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Ages 15-64	2	3	2	0	1	2	2	1	2	2	1	1
Ages 65 plus	3	7	5	4	4	1	3	1	3	4	5	2
Total CDI*	5	10	7	4	5	3	5	2	5	6	6	3

Cleaning Compliance (%)

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Board Total	94	94	94	94	94	93	94	93	93	94	94	94

Estates Monitoring Compliance (%)

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Board Total	92	93	93	94	94	95	94	93	93	93	92	93

PERTH ROYAL INFIRMARY REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
MRSA	0	1	0	0	0	0	0	0	0	0	0	0
MSSA	0	1	0	0	0	2	1	0	0	0	3	0
Total SABs*	0	2	0	0	0	2	1	0	0	0	3	0

Clostridium difficile infection monthly case numbers

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	1	1	1	0	1	1	1	0	0
Total CDI*	0	0	0	1	1	1	0	1	1	1	0	0

Cleaning Compliance (%)

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Board Total	94	94	94	96	96	92	89	96	95	92	94	96

Estates Monitoring Compliance (%)

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Board Total	100	100	100	100	98	99	97	100	99	100	99	100

* See Appendix 3 for related SAB information and Appendix 4 for CDI information.

NHS TAYSIDE
ROYAL VICTORIA HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	1	0	0	1	1	0	1	0	0	0	0
Total SABs*	0	1	0	0	1	1	0	1	0	0	0	0

Clostridium difficile infection monthly case numbers

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	2	0	0	1	0	0	0	0	0
Total CDI*	0	0	0	2	0	0	1	0	0	0	0	0

Cleaning Compliance (%)

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Board Total	94	96	95	96	97	95	95	96	97	96	95	96

Estates Monitoring Compliance (%)

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Board Total	99	100	97	99	100	100	99	100	98	100	99	100

STRACATHRO HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	1	0	0	0	0
Total SABs*	0	0	0	0	0	0	0	1	0	0	0	0

Clostridium difficile infection monthly case numbers

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	0	0	0	0	0	0	0	0
Total CDI*	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Board Total	96	96	94	92	92	96	95	92	91	94	93	98

Estates Monitoring Compliance (%)

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Board Total	99	99	96	100	97	99	99	98	98	99	97	96

* See Appendix 3 for related SAB information and Appendix 4 for CDI information.

NHS TAYSIDE COMMUNITY HOSPITALS REPORT CARD

The community hospitals covered in this report card include:

- Strathmartine Hospital
- Dudhope Young Persons Unit
- Arbroath Infirmary
- Aberfeldy Community Hospital
- Blairgowrie Community Hospital
- Murray Royal Hospital
- St Margarets Hospital, Auchterarder
- Brechin Infirmary
- Montrose Royal Infirmary
- Crieff Community Hospital
- Carseview Centre
- Whitehills Health & Community Care Centre
- Pitlochry Community Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	2	1	0	0	0	0	0	0	0	0	0
Total SABs	0	2	1	0	0	0	0	0	0	0	0	0

***Clostridium difficile* infection monthly case numbers**

	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	1	0	0	0	0	0	0	2	0	0
Total CDI	0	0	1	0	0	0	0	0	0	2	0	0

See Appendix 3 for related SAB information and Appendix 4 for CDI information

NHS OUT OF HOSPITAL REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

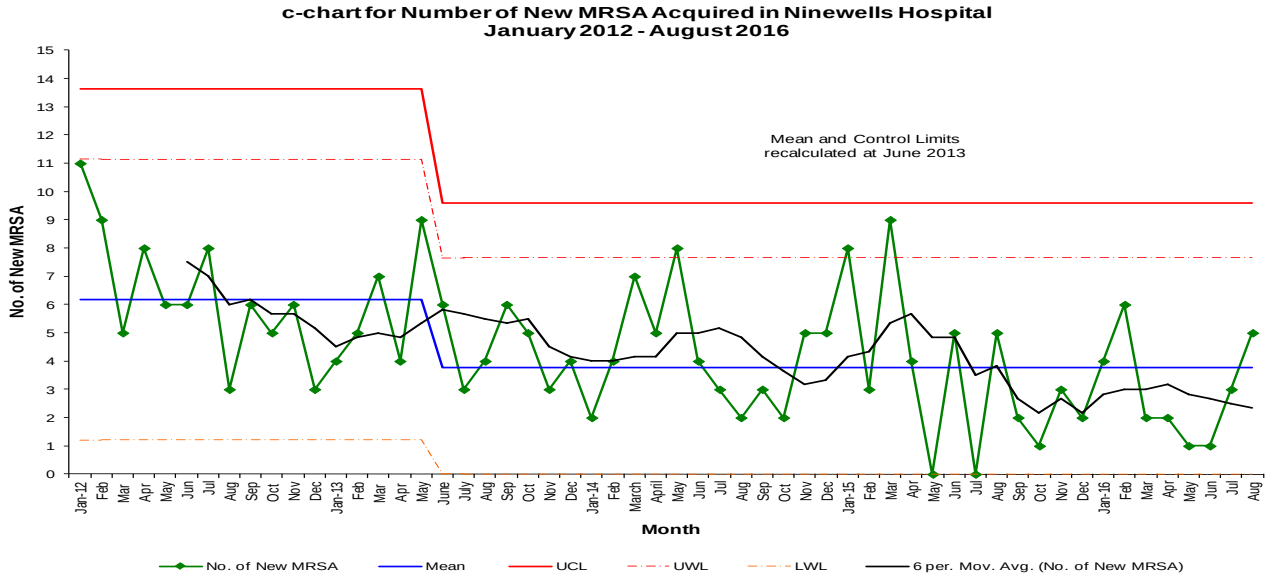
	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
MRSA	1	1	0	0	0	0	0	1	0	0	0	0
MSSA	7	3	2	9	7	7	8	8	3	10	5	9
Total SABS	8	4	2	9	7	7	8	9	3	10	5	9

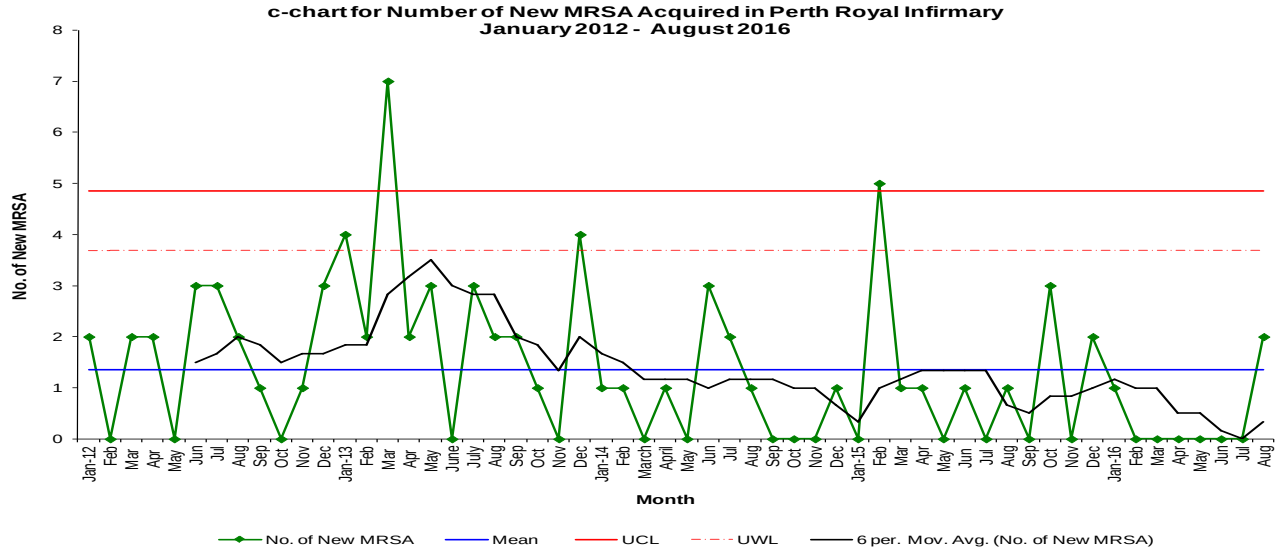
***Clostridium difficile* infection monthly case numbers**

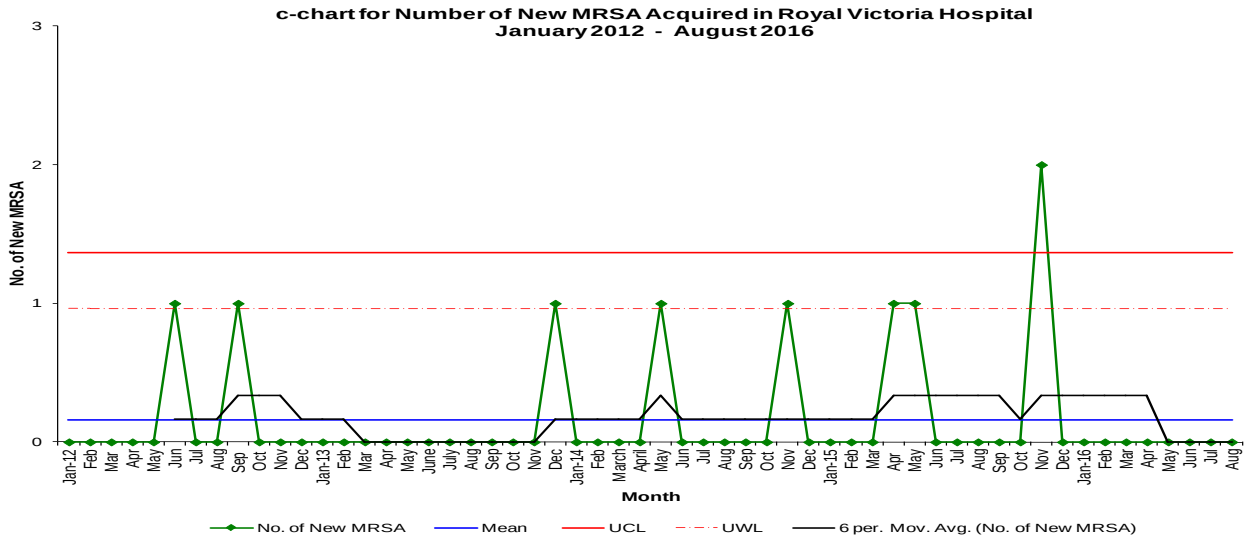
	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	July 2016	Aug 2016
Ages 15-64	5	3	1	4	0	1	2	0	3	2	1	1
Ages 65 plus	3	2	4	2	4	3	2	4	4	1	3	5
Total CDI	8	5	5	6	4	4	4	4	7	3	4	6

MRSA **Appendix 1**

MRSA KPIs: No outbreaks were reported and the figure for new MRSA acquisition is within natural variation parameters.

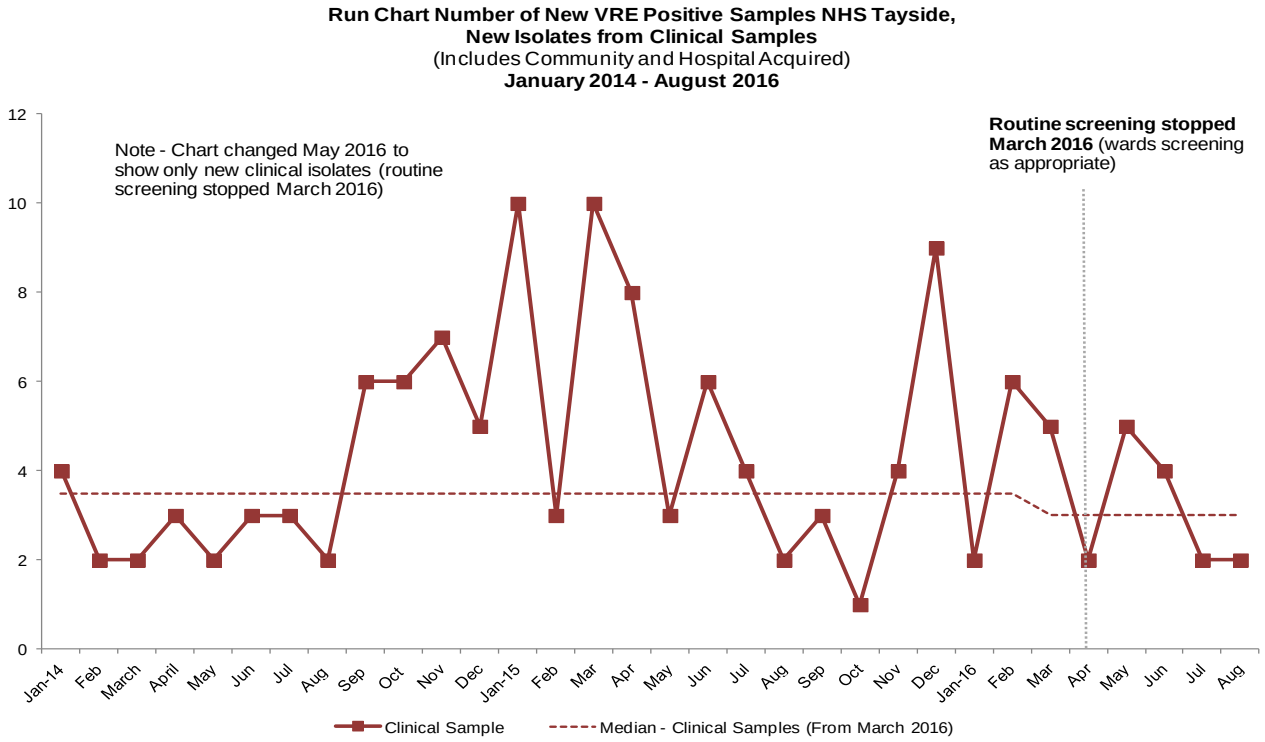






Vancomycin-resistant Enterococcus (VRE) Appendix 2

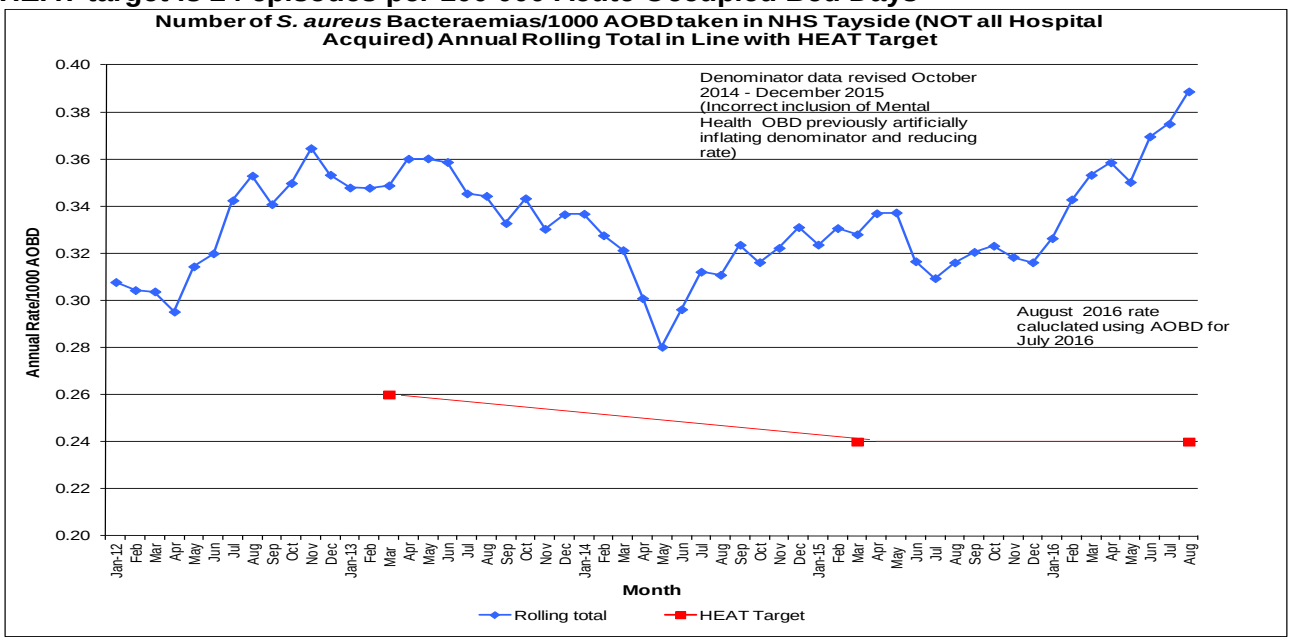
Nil to report. Clinical isolates remain stable with few invasive isolates from sterile sites (e.g. blood cultures).



This chart now shows only new isolates from clinical samples as routine screening was discontinued in March 2016.

Staph aureus bacteraemias (SABs) Appendix 3

HEAT target is 24 episodes per 100 000 Acute Occupied Bed Days

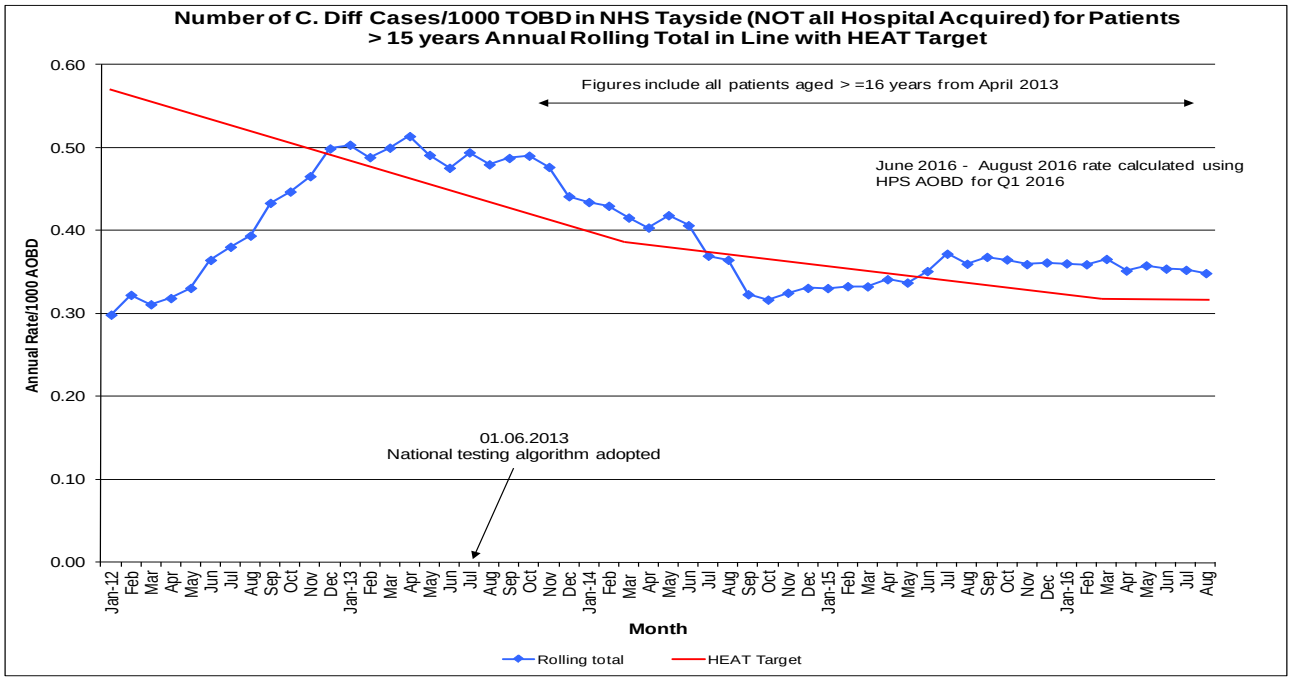


Significant proportion (about half) is associated with community acquisition. Where infections are hospital acquired, the single biggest group is associated with vascular access devices though often the source of infection is difficult to identify. Most patients have underlying risk factors.

It is of note that the trend for the rate has gone upwards over the past 8 months, despite the number of actual cases over the past 6 months reducing (from 80 between September 2015 and end of February 2016 : there are 69 from March to end of August). This is because of the reduction

in the denominator beds since January of this year. Health Protection Scotland has been informed of the impact of the AOBD reduction on the rate.

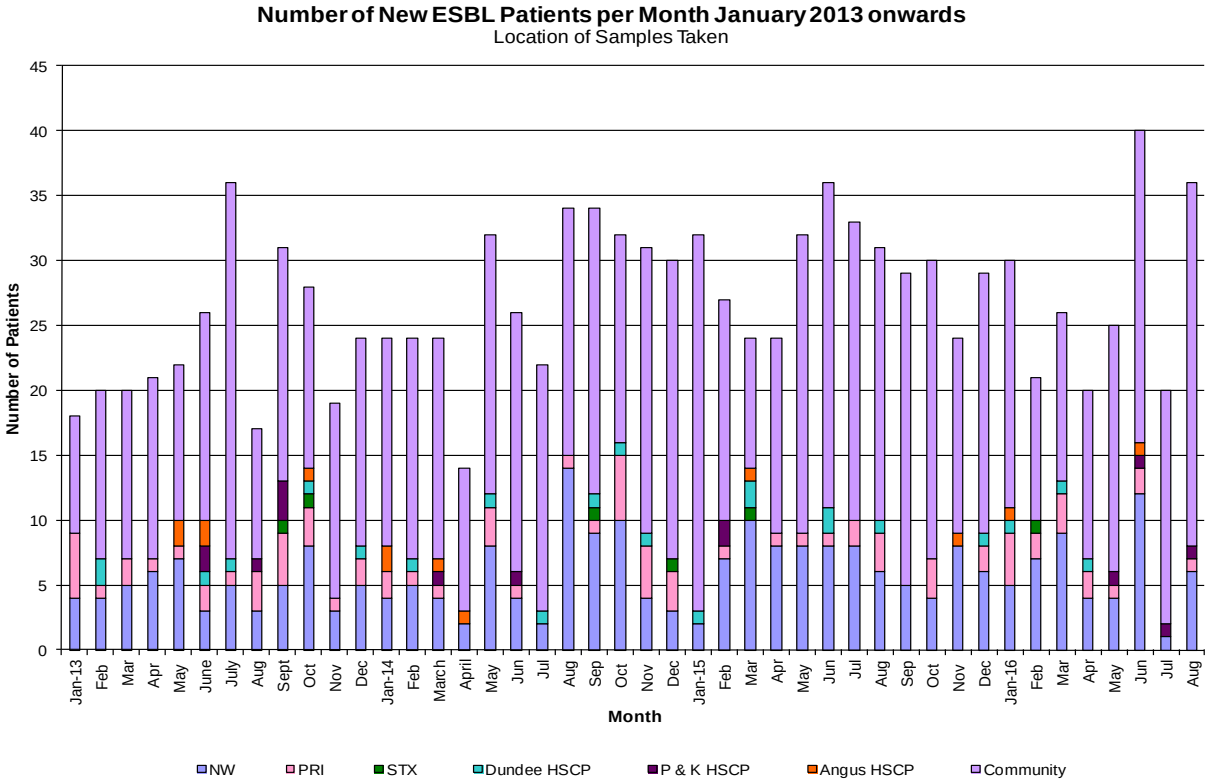
C.difficile Infection (CDI) HEAT target is 32 over the age of 15 years per 100 000 Occupied Bed Days. **Appendix 4 NHS Tayside HEAT Target**



CDI rate is stable with no outbreaks but above the target.

ESBLs and other multi-drug resistant Gram-negative bacteria **Appendix 5**

No significant change or triggers breached in any single ward, though there continues to be small numbers of new cases detected. Allocating place of acquisition is difficult, as there is a mixture of hospital and community acquired cases. The place of detection is not necessarily the place of acquisition.



Carbapenemase Producing Enterobacteriaceae (CPE)
NHS Tayside is progressing with the requirement to screen for CPE in line with National recommendations and in addition has locally enhanced surveillance. Screening is included in the Clinical Risk Assessment documentation and education and awareness raising continues. These can arise in the community as well as in hospital settings. No new cases identified in these months. New screening guidelines were issued by HPS and NHS Tayside is complying with these with a local enhancement.

Antimicrobial Prescribing **Appendix 6**

Secondary Care Audit Process

For 2016/17 the SAPG national antimicrobial prescribing indicator requires data to be collected to provide the following information for two downstream wards on each site (Ninewells Wards 6 & 8 and PRI Wards1 & 6):

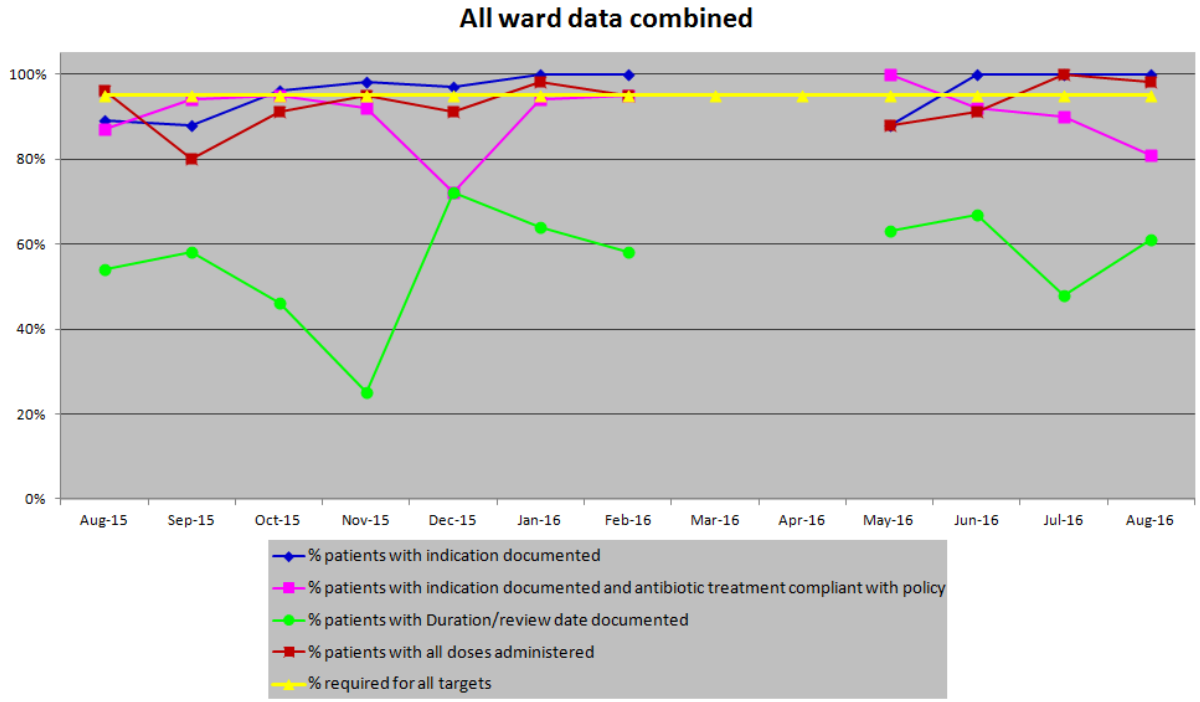
- missed doses of antibiotics
- duration/review date of antibiotic documented
- indication documented in notes
- antibiotic compliance with local guidance.

To ensure continuity and quality of monthly data for national and local submission, the data collection and reporting process has been updated. The Antimicrobial Pharmacist and Nurse collect monthly data and will continue to do so until all clinical teams can be engaged in this process. The Antimicrobial Management Team (AMT) provide support around all areas of this data collection and review results monthly to identify any issues of concern which are fed back to the clinical teams for education and improvement.

The required target for each element detailed above is 95% compliance. Figure 1 shows the NHS Tayside data to August 2016.

Work is ongoing to highlight the need for clear documentation of indication and duration/review in medical notes and on medicine charts through education sessions and the AMG 5 key messages issued after each meeting.

Figure 1: Combined % Compliance with nationally required target



Compliance with antibiotic guidance within NHS Tayside is reported quarterly to clinical teams in selected wards. Other areas are auditing antimicrobial prescribing according to local needs. The AMT continue to provide support and guidance around all aspects of antimicrobial prescribing within NHS Tayside. SAPG and the NHS Scotland HAI Standards require that AMTs are confident that the levels of antibiotic compliance are maintained.

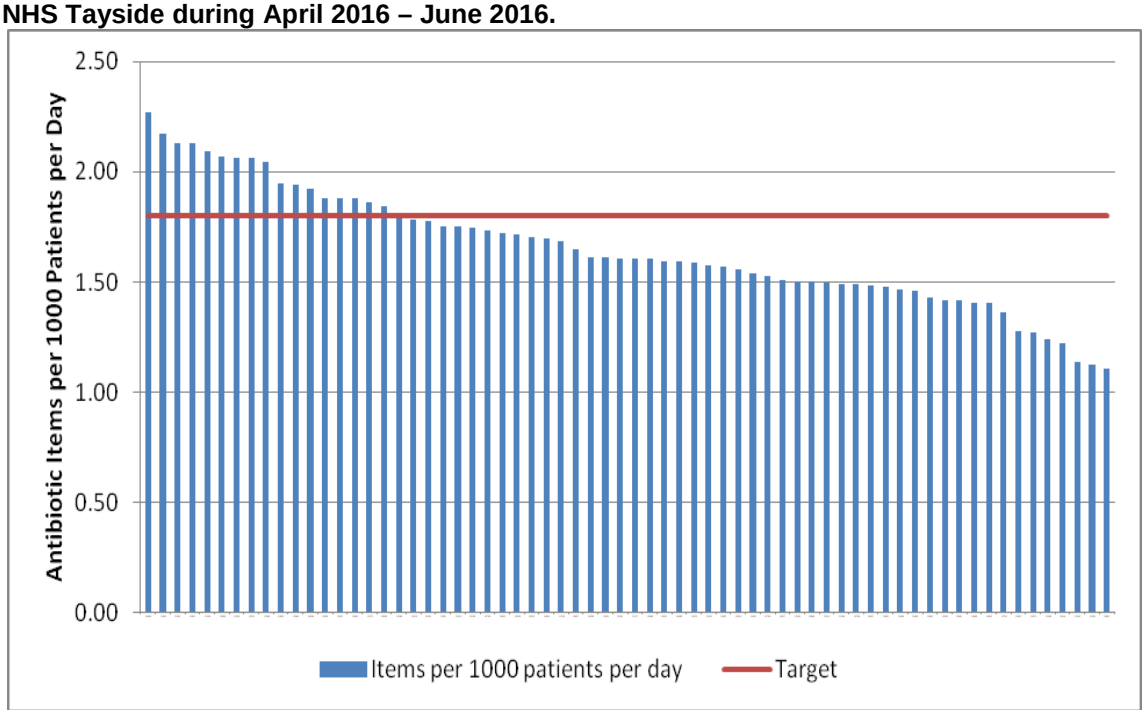
The inappropriate and excessive use of prescribing carbapenem antibiotics (e.g. meropenem) has been recognised nationally as a serious threat to our ability to treat multi-resistant pathogens. To address this ward based pharmacy staff identify patients prescribed meropenem and alert the antibiotic pharmacy team of these patients. Patients prescribed meropenem are then reviewed by microbiologists or the infectious diseases medical staff to ensure use is appropriate. Meropenem use is reviewed at each AMG meeting.

Primary Care

The primary care National Therapeutic Indicators (NTI) has not been set for 2016-17, but is likely to continue to include an indicator for overall use of antibiotics. The aim of reducing total antibiotic prescribing is likely to prove to be challenging and practices have been signposted to supporting resources such as audit templates and educational packages as well as individual support from AMG members. Figure 2 outlines the spread of antibiotic prescribing in general practice within NHS Tayside based on the targets set for the 2015-16 NQI.

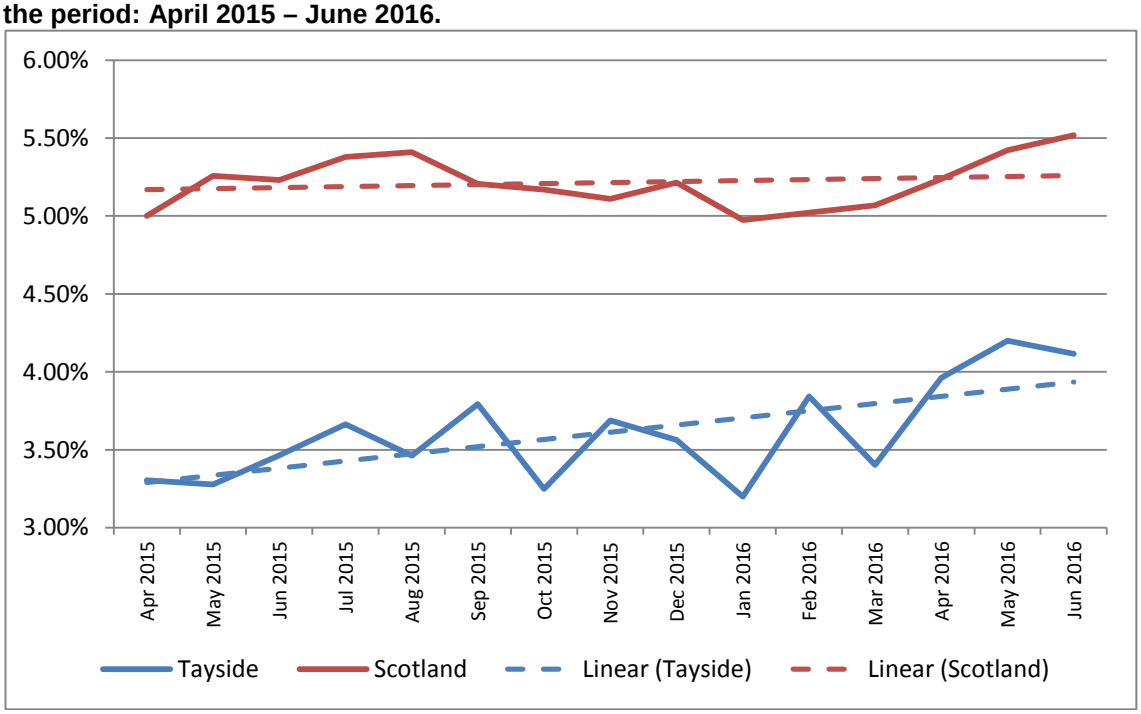
Whilst the '4-C' antibiotic groups which have the highest risk of contributing to CDI are no longer formally measured as a HEAT target, it remains a priority to monitor and follow up outlying prescribing patterns of these agents in primary care. Overall however the level of prescribing of these antibiotics remains low, relative to overall antibiotic prescribing, see Figure 3.

Figure 2: NHS Tayside and Scotland: - Antibiotic Items per 1000 patients per day for each practice in NHS Tayside during April 2016 – June 2016.



In this quarter, 95% of practices have met the required target or shift (72% reaching the target and 15% achieving the shift); with only 5% not meeting either the target or shift.

Figure 3: NHS Tayside and Scotland: - 'C-diffogenic' antibacterials as a % of all antibacterials during the period: April 2015 – June 2016.



The sustained low level in 'c-diffogenic' antibiotic prescribing has been very encouraging. The very slight upward trend will continue to be monitored.

Surgical Site Infection Surveillance (SSI) Appendix 7

Surveillance continues as per National requirements.

Local surveillance figures including 30 day post discharge figures where appropriate.
NOF = neck of femur Hip = Total hip replacement Knee = total knee replacement

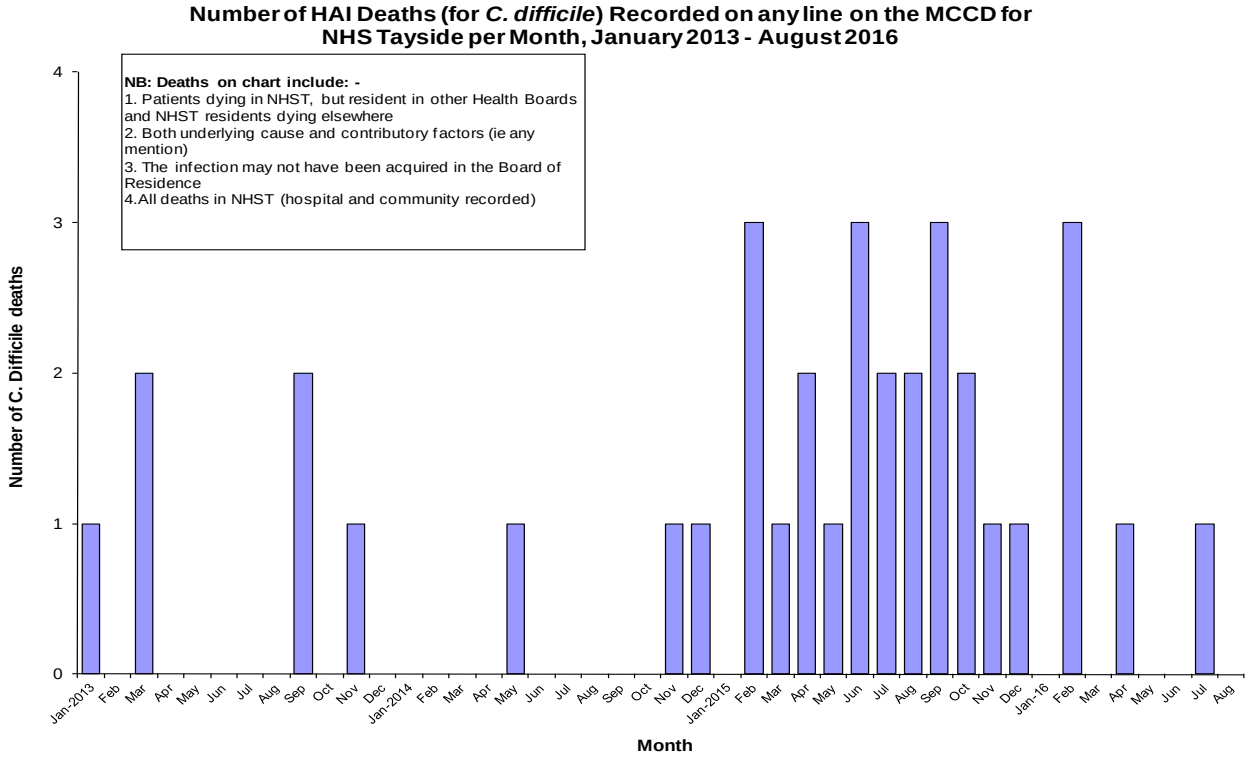
Month	C section no. (% infection)	NOF no. (% infection)	Hip no. (% infection)	Knee no. (% infection)	Colorectal no. (% infection)
July	117 (0)	48 (0)	63 (0)	52 (4)	30 (23)
Aug	119 (2)	44 (0)	48 (4)	55 (2)	22 (14)
Sept.	118 (2)	51 (2)	73 (4)	66 (5)	20 (0)
Oct.	106 (0)	46 (0)	52 (2)	40 (2.5)	19 (0)
Nov	94 (2)	40 (0)	66 (0)	51 (4)	20 (10)
Dec	88 (0)	53 (0)	62 (0)	47 (0)	20 (10)
Jan 15	87 (2)	43 (2)	64 (6)	35 (3)	22 (18)
Feb	84 (2)	34 (0)	53 (6)	35 (0)	23 (4)
Mar	117 (3)	29 (0)	70 (4)	39 (3)	24 (25)
Apr	103 (4)	49 (0)	52 (0)	38 (0)	18 (11)
May	112 (2)	44 (0)	51 (2)	37 (0)	13 (15)
June	140 (3)	25 (0)	61 (3)	44 (2)	28 (14)
July	122 (2)	52 (0)	60 (0)	32 (3)	17 (6)
Aug	116 (4)	46 (2)	61 (0)	45 (0)	29 (10)
Sept	109 (3)	46 (4)	61 (0)	50 (0)	34 (21)
Oct	103 (6)	41 (0)	62 (3)	47 (0)	14 (7)
Nov	81 (1)	49 (0)	70 (0)	38 (0)	27 (0)
Dec	89 (7)	55 (0)	58 (0)	45 (0)	19 (21)
Jan 16	91 (3)	48 (2)	68 (0)	34 (0)	26 (15)
Feb	84 (2)	36 (0)	88 (2)	51 (0)	18 (33)
March	92 (3)	42 (0)	64 (0)	46 (0)	19 (21)
Apr	73 (5)	48 (0)	66 (2)	38 (0)	21 (10)
May	120 (5)	43 (0)	75 (1)	49 (0)	25 (12)
June	107 (7)	48 (0)	77 (6)	46 (0)	32 (6)
July	No data	42 (2)	57 (0)	38 (0)	No data
August					

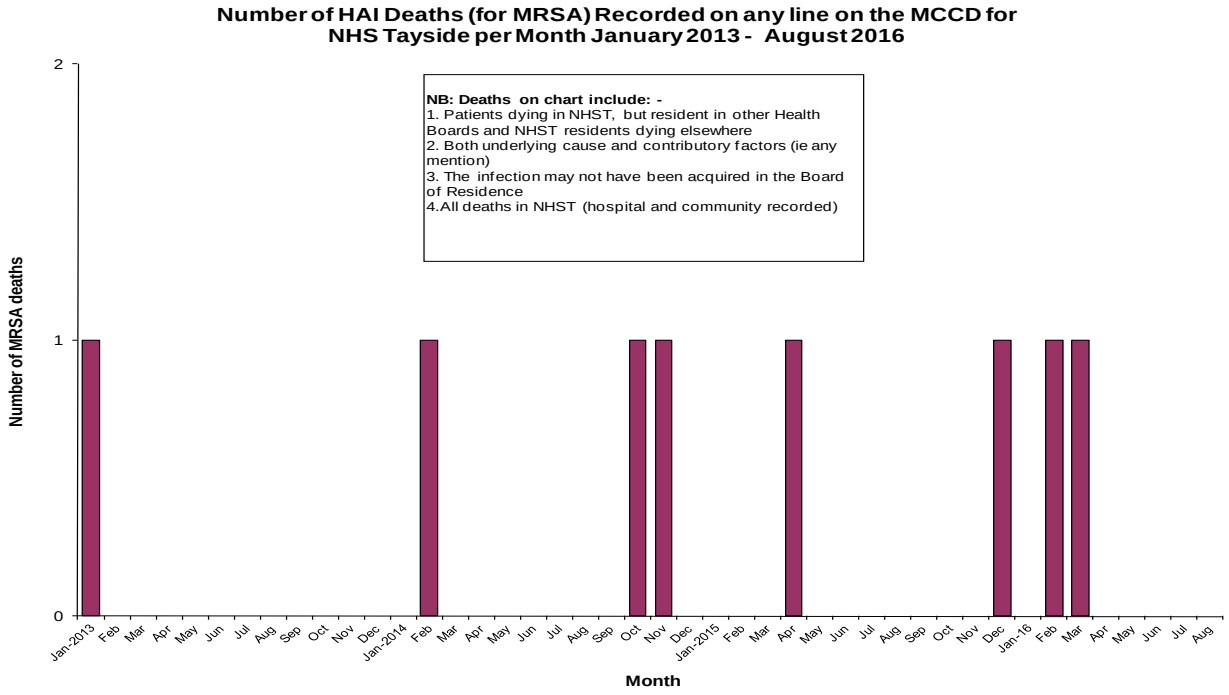
No exceptions to report for SSI this report

Hot Topics/ Horizon Scanning — Appendix 8

- Single room provision: limited single rooms entered as a risk for the organisation.
- Increase in negative pressure rooms required in level 2/3 areas: entered as a risk for the organisation in relation to the ability to deliver care for patients with possible or confirmed MERS-CoV or Avian influenza.
- Multi-resistant gram-negative bacteria for which antibiotic treatment is severely restricted. We are seeing a small increase in the number of these bacteria being identified in the laboratory. Staff awareness on the need to screen for these in high risk groups is increasing.

HAI and Medical Certification of Death: MRSA and CDI — Appendix 9




Number of HAI Deaths (for MRSA) Recorded on any line on the MCCD for NHS Tayside per Month January 2013 - August 2016
NB: Deaths on chart include: -
1. Patients dying in NHST, but resident in other Health Boards and NHST residents dying elsewhere
2. Both underlying cause and contributory factors (ie any mention)
3. The infection may not have been acquired in the Board of Residence
4.All deaths in NHST (hospital and community recorded)
Number of MRSA deaths
2
1
0
Jan-2013
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan-2014
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan-2015
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan-16
Feb
Mar
Apr
May
Jun
Jul
Aug
Month

HEI Inspections **Appendix 10**

Update – September 2016

Previous Inspections to NHS Tayside by HEI:-

Announced

- Arbroath Infirmary – March 2016 (Complete)
- Stracathro Hospital – May 2012 (Complete)
- Perth Royal Infirmary - May 2010 (Complete)
- Ninewells Hospital - November 2009 (Complete)

Unannounced

- Ninewells Hospital – January 2016
- Perth Royal Infirmary – November 2015 (Complete)
- Stracathro – July 2015 (Complete)
- Ninewells Hospital – March 2014 (Complete)
- Perth Royal Infirmary – December 2013 (Complete)
- Stracathro – April 2013 (Complete)
- Ninewells Hospital – October 2012 (Complete)
- Perth Royal Infirmary – February 2012 (Complete)
- Ninewells Hospital – November 2011 (Complete)
- Stracathro Hospital – May 2011 (Complete)
- Ninewells Hospital – April 2011 (Complete)
- Ninewells Hospital – November 2010 (Complete)

Arbroath, March 2016

An announced inspection took place to Arbroath Infirmary on 2nd March 2016. This was the first inspection to a community facility within NHS Tayside and resulted in 2 requirements related to decontamination of patient equipment and a small number of non-compliances with infection control policies. The report and improvement action plan were published on Tuesday 17th May 2016. 16 week follow-up improvement action plan was submitted 6th July 2016 with required actions complete.

Ninewells, January 2016

An unannounced inspection took place to Ninewells Hospital on 12th and 13th January 2016 resulting in one requirement in relation to compliance with Health Protection Scotland (HPS) guidance on the use of personal protective equipment. The 16 week follow-up improvement action plan was submitted May 2016 with the one outstanding requirement being the subject of continued discussion at a national level. It is welcome to note that NHS Tayside was commended on significant improvement since the last inspection in March 2014.

Glossary **Appendix 11**

AOBD – Acute Occupied Bed Days

'Alert' organisms- The microbiology department supply the clinical groups with daily reports of alert organisms that are likely to cause outbreaks of infection and /or are multi –drug resistant.

Antimicrobials- An antimicrobial is a substance that kills or inhibits the growth of microbes such as bacteria (antibacterial activity), fungi (antifungal activity), viruses (antiviral activity), or parasites (anti-parasitic activity).

Bacteraemia- Bacteraemia is the presence of bacteria in the blood. It is the principal means by which local infections spread to distant organs.

Carbapenemase Producing Enterobacteriaceae (CPE). Coliforms (bowel bacteria) producing enzymes that break down a wide range of antibiotics. National guidelines for screening and isolation. Found mainly outwith Scotland at this time in certain parts of the UK but is more common in Asia, Southern Europe and other parts of the world. Considered to have the potential to be one of the most significant threats to public health

C difficile- *Clostridium difficile* is a species of bacteria called *Clostridium, which* are anaerobic spore-forming rods. It causes a range of symptoms from diarrhoea through to a severe inflammation of the large bowel pseudomembranous colitis. Although part of the normal gut flora in about 5% of the adult population, infection can occur after normal gut flora is altered by the use of antibiotics. Treatment is by stopping antibiotics and commencing specific anti-clostridial antibiotics, e.g. metronidazole. CDI is short for *Clostridium difficile* Infection.

Cohorting. The grouping together of patients with the same infection/symptoms to reduce risk of spread to unaffected individuals: so for instance there may be a bay of patients with symptoms of diarrhoea and a separate bay where patients are not symptomatic. It can be done by bay (or rarely by ward). It would be started when the capacity to care for such affected patients exceeds the number of single rooms. It preferably should include dedicated facilities for positive (affected) or negative (not affected) cohort patients and may or may not be managed with cohort nursing staff.

DDD. Defined daily dose. The DDD is the assumed average maintenance dose per day for a drug used in its main indication in adults.

ESBLs. Extended spectrum beta-lactamase enzyme producers. These are bacteria like *E coli* which cause a range of infections such as urinary tract infections or blood poisoning and have acquired the ability to produce the ESBL enzymes. This means these germs are able to destroy all antibiotics in the penicillin and cephalosporin classes. Often these bacteria are resistant to other types of antibiotic and this leaves a very restricted choice for treatment and often the patient needs intravenous treatment. Mostly seen in community settings at the moment.

HEAT- HEAT targets are a core set of Ministerial objectives, targets and measures for the NHS. HEAT targets are set for a 3-year period and progress towards them is measured through the Local Delivery Plan process.

MRSA - Meticillin-resistant *Staphylococcus aureus*, (MRSA) is a specific strain of the *Staphylococcus aureus* bacterium that has developed antibiotic resistance, first to penicillin since 1947, and later to meticillin and related anti-staphylococcal drugs (such as flucloxacillin). Popularly termed a "superbug", it was first discovered in Britain in 1961 and is now widespread throughout the UK. There are still antibiotics left that can deal with this infection. More often than not it colonises (i.e. lives as part of the normal flora of the individual) rather than infects, but if the normal defence systems are breached for instance following an operation or if a line is put into a vein, infection can result.

Norovirus - A group of related viruses, including Norwalk and Norwalk-like viruses that can cause stomach pain, diarrhoea, and vomiting in humans.

PVL - Panton Valentine Leucocidin. A potent toxin (poison) produced by staphylococci (MRSA and MSSA) which attacks white blood cells. Most frequently seen in community isolates and often in children. It can cause a range of effects from simple but recurrent abscess through to a serious infection like pneumonia.

Quinolone antibiotics- The quinolones are a family of broad-spectrum antibiotics.

Surgical prophylaxis- Surgical prophylaxis is the use of antibiotics usually a single dose at the time of the operation to prevent infections at the surgical site.

Vancomycin resistant enterococci. Enterococci are a normal part of human bowel flora. They rarely cause infection and if they do tend to be UTIs. Can cause bacteraemia in at risk patients. The ‘ALERT’ antibiotic sensitivity pattern (vancomycin resistance) is readily traceable. These usually colonise rather than infect. Other antibiotic choices are available if treatment is required.

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item 8.2

NHS Tayside

BOARD108/2016
Tayside NHS Board
27 October, 2016

CORPORATE FINANCIAL REPORT FOR PERIOD ENDED 30 SEPTEMBER, 2016

1. PURPOSE

The purpose of this report is to advise Tayside NHS Board of the financial position of NHS Tayside as at 30 September, 2016.

2. RECOMMENDATION

Tayside NHS Board is requested to;

- Note the current position and support the actions being taken to contain spend.
- Approve the non recurring release of the Board Contingency on a proportionate basis each month to recognise the range of cost pressures that are evident across the system

3. EXECUTIVE SUMMARY

3.1 Financial Performance for the period to 30 September, 2016

NHS Tayside is reporting an overspend of £7.751 million for the half year to 30 September, 2016, (last month £6.165 million). The position is summarised in Table 1 below:-

Table 1 - Operating Cost for the period to 30 September, 2016

	Annual Plan	Plan to Date	Actual to Date	Over/ Under(-)
	£000s	£000s	£000s	£000s
Core Operational Unit				
Access Group	71,638	36,500	35,660	-840
Medicine Group	118,874	60,375	62,343	1,968
Specialist Services Group	69,284	34,623	35,477	854
Surgery and Theatres Group	88,367	45,267	47,012	1,745
Regional Mental Health Services	6,250	3,214	3,110	-104
Tayside Communities	12,766	5,902	5,895	-7
Facilities & Operational Services	74,018	36,326	35,829	-497
OU Committed Earmarks	2,726	700	0	-700
Total Core Operational Unit	**443,923**	**222,907**	**225,326**	**2,419**
Integrated Joint Boards				
Angus	104,436	50,464	51,265	1,928
Dundee	154,213	74,729	76,526	1,797
Perth & Kinross	123,836	60,422	61,656	1,234
Total Integrated Joint Boards	**382,485**	**185,615**	**189,447**	**3,832**
Board/OU Corporate				
Area Wide Corporate Services	41,070	16,710	16,500	-210
Operational Unit Corporate Services	11,735	8,176	7,911	-265
Other Healthcare Services	21,549	10,950	11,640	690
Income	-17,299	-8,433	-8,330	103
Income from Other Boards & NES ACT	-62,779	-31,430	-31,664	-234
Depreciation	21,045	10,685	10,685	0
Profit (-)/Loss on disposal of Assets	-4,500	-212	-212	0
Board Committed Earmarks	14,404	-2,916	0	2,916
Board Reserves	4,300	1,500	0	-1,500
Total Board Corporate	**29,525**	**5,030**	**6,530**	**1,500**
Net Operating Cost for NHS Tayside	**855,933**	**413,552**	**421,303**	**7,751**

3.2 Key Issues to Note

- The Board submitted an unbalanced 2016/17 Local Delivery Plan (LDP) to Scottish Government Health & Social Care Directorate (SGHSCD) in May 2016. The results at the end of September recognise a full six months of the £11.65 million identified in the LDP. This totals £5.825 million, with £2.909 million recognised in the IJBs and the balance of £2.916 million identified in the mainstream accounts.
- An element of the Board contingency set aside as part of the Financial Framework has been provisionally released to reflect the impact of surge beds costs to September and the impact of "hard to recruit to" medical posts. The impact of non compliant rotas has also been recognised. The sum released totals £1,500k.
- Current year cash savings requirements (CRES) are reflected in the financial position. Progress against the workstream programme is reported to the Transformation Programme Board. At the end of the six month period, efficiency savings delivery is £1.887 million behind trajectory.
- The three Integrated Joint Boards (IJB) proposals on efficiency savings were considered by each of the governing Boards in June.
- The IJBs have intimated their intention of invoking the Risk Sharing Agreement, particularly in respect of the devolved GP Prescribing budget and the risk around delivery.

3.3 Subjective Spend Analysis

The analysis of the overspend at 30 September, 2016, of £7.751 million by subjective heading is provided in Table 2 below:-

Table 2 – Subjective Analysis for the period ended 30 September, 2016

	Annual Plan	Plan to Date	Actual to Date	Over/ Under(-)
	£000s	£000s	£000s	£000s
Pay	518,424	261,769	263,077	1,308
Prescribing	136,509	67,948	70,731	2,783
Other Non Pay	162,955	72,054	73,209	1,155
FHS- Unified & Non Discretionary	115,157	57,769	57,585	-184
Resource Transfer & Voluntary Sector	21,345	10,543	10,535	-8
Other Healthcare Services	23,865	12,063	12,569	506
Depreciation & Profit/Loss on Asset Disposal	16,545	10,473	10,473	0
Income	-145,429	-76,500	-76,876	-376
Service efficiencies yet to be identified	-13,616	-1,851	0	1,851
Committed earmarks	15,878	-2,216	0	2,216
Reserves	4,300	1,500	0	-1,500
Total	**855,933**	**413,552**	**421,303**	**7,751**

The three elements of Pay, Prescribing and Other Non-Pay are considered in more detail below.

3.4 Pay Costs and Workforce

The analysis by job family is presented in Table 3 below:-

Table 3 – Pay Costs by Job Family

Pay	Annual Plan	Plan to Date	Actual to Date	Over/ Under(-)
	£000s	£000s	£000s	£000s
Medical & Dental	126,672	63,937	64,316	379
Nursing	202,317	103,549	106,085	2,536
Health Science Services	21,807	10,550	10,321	-229
Allied Health Professionals	35,791	18,028	17,796	-232
Other Therapeutic	19,014	9,496	9,223	-273
Medical & Dental Support	5,278	2,884	2,742	-142
Administrative Services	63,654	31,909	30,728	-1,181
Senior Managers	6,120	3,056	2,648	-408
Support Services	37,815	18,360	18,371	11
Personal and Social Care	1,577	832	847	15
Vacancy Factor	-1,621	-832	0	832
Total	**518,424**	**261,769**	**263,077**	**1,308**

A number of pay issues were dealt with through the legacy aspect of the NHS Tayside Financial Framework 2016/17.

Chart 1 - Monthly Pay Cost Trend April 2015 – September 2016

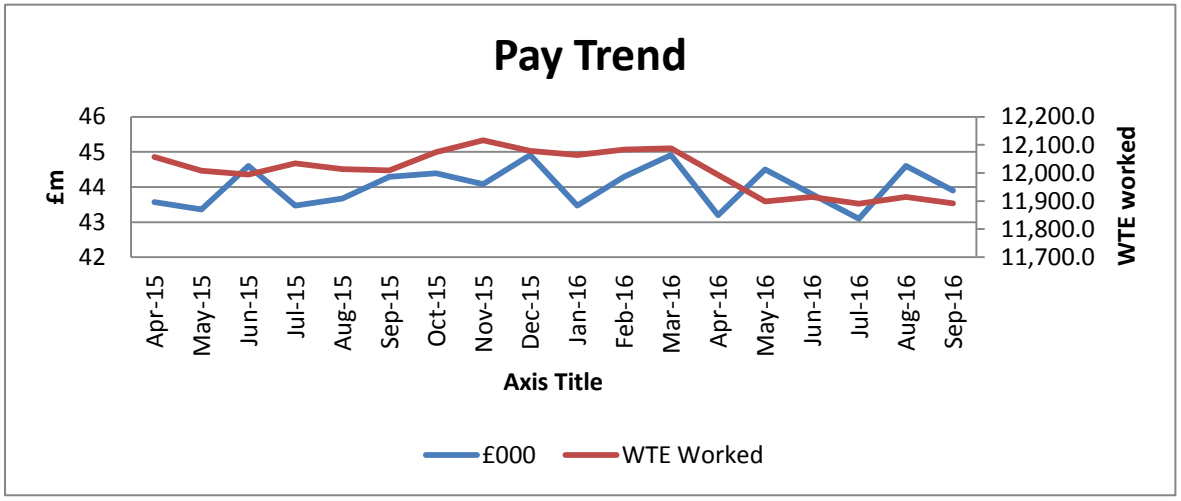


Table 4 – Monthly Profile

	£m				WTE Worked		
Staff Group	**Ap-Jul**	**Aug-16**	**Sep-16**		**Ap-Jul**	**Aug-16**	**Sep-16**
Medical & Dental	42.17	10.61	10.93		1,166.3	1,188.6	1,192.6
Nursing & Midwifery	70.68	17.98	17.70		5,313.9	5,277.6	5,259.8
Healthcare Sciences	6.76	1.7	1.71		484.8	483.7	492.1
Allied Health Professionals	11.83	3.02	2.97		853.5	867.9	863.7
Other Therapeutic	6.14	1.54	1.55		401.7	402.7	402.2
Medical & Dental Support	1.87	0.47	0.47		170.6	171.5	168.3
Admin & Clerical	20.42	5.13	5.11		1,992.7	1,974.8	1,974.3
Senior Managers	1.77	0.44	0.44		73.2	72.2	71.5
Support Services	12.06	3.52	2.88		1,431.7	1,437.8	1,430.6
Personal and Social Care	0.56	0.14	0.14		33.1	34.1	34.0
Total	**174.26**	**44.55**	**43.90**		**11,921.5**	**11,910.9**	**11,889.1**

Table 5 – Supplementary Costs

Supplementary Costs	Cumulative April – Sep		
	2015/16	2016/17	Inc/(Dec)
	£000s	£000s	£000s
Excess Part Time Hours	1,776	1,612	(164)
Overtime	1,545	1,637	92
Bank	2,507	2,600	93
Agency Costs	4,906	4,775	(131)
Total	**10,734**	**10,624**	**(110)**

Supplementary Costs in graphical format are provided at Appendix 1 of the report.

Over 60% of the Board's running costs are consumed by workforce costs.

Whole Time Equivalent (wte) worked has fallen by 220 wte since March 2016. Nursing & Midwifery and Admin & Clerical/Senior Managers are the main contributors. This lower level of employed staffing has contributed to a reduction of approximately £3.2 million in the Board's profile of spend over the first six months in comparison with the same period last year.

Non compliant rotas for Training Grade Medical staff add £0.5 million to the financial position.

A level of winter surge beds have remained within the system since the start of the financial year due to capacity and flow issues. This has added £0.6 million to the position at the half year period.

Expenditure on supplementary costs (excess part time costs, overtime, bank and agency) to 30 September is £10.624 million, representing a reduction of £110k on the same period last year. Nursing external agency costs at close to £2.5 million for the 6 month period are close to 10% lower but still reflect an average of close to 45 wte engaged at the premium rate over the 6 month period.

The engagement of close to 200 Newly Qualified Practitioners and their deployment over the next month will require to be carefully managed in order to mitigate both agency costs from the system as well as reducing the level of requests for bank cover.

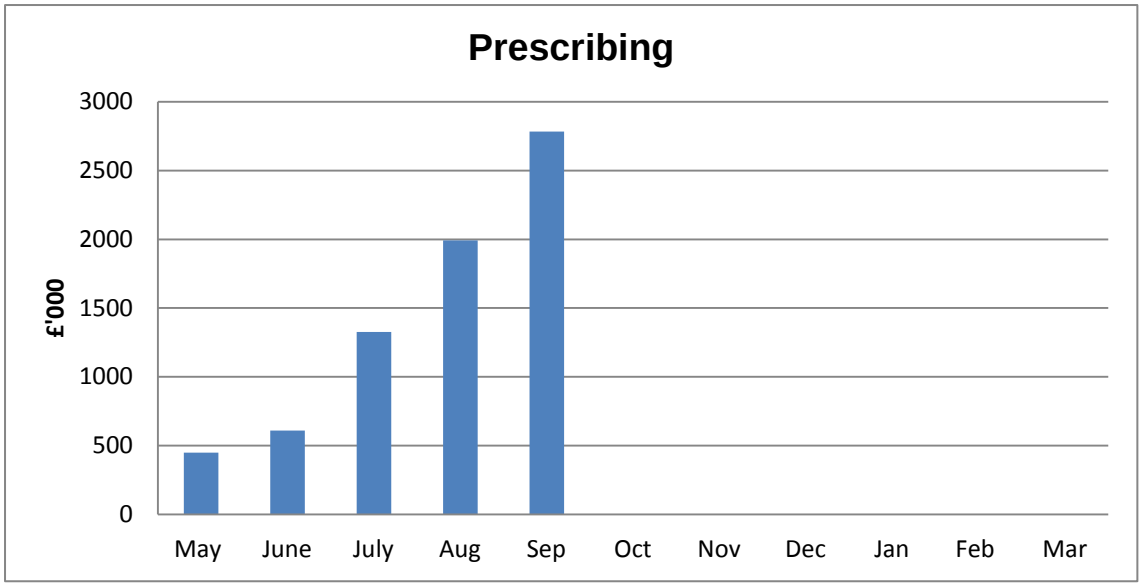
eRostering continues to be rolled out across the organisation, which, together with the Safecare system, will significantly enhance the Board's ability to provide timely, robust information to ensure the efficient deployment of the workforce resource. A range of metrics are being adopted that will provide an increased level of scrutiny with the intention of placing improved controls on the cost base.

3.5 Prescribing

Table 6 – Prescribing Costs

	Annual Plan	Plan to Date	Actual to Date	Over/ Under(-)
	£000s	£000s	£000s	£000s
FHS-Angus IJB	20,842	10,498	11,710	1,212
FHS-Dundee IJB	33,235	16,733	17,772	1,039
FHS Perth & Kinross IJB	26,153	13,162	14,072	910
Hospital & Community	56,279	27,555	27,177	-378
Total	**136,509**	**67,948**	**70,731**	**2,783**

Chart 2



The FHS Prescribing position of £3.161 million includes £0.205 million from 2015/16, principally as a consequence of an error in a national pricing file and the recognition of the £2 million efficiency savings target that at an early stage in the year was considered undeliverable in the current year and was recognised in the unbalanced LDP submission to Scottish Government.

All parties continue to work collaboratively to ensure existing programmes are delivered in a timely manner and that new areas for scrutiny and action are investigated. At this stage £1.3 million is anticipated to be delivered from the current programme against a revised target of £2.5 million.

The Board must not however lose sight of the raw statistic that in comparison with the national spend pattern that it remains an outlier.

Table 7 – FHS Prescribing – Apr to Jul 2016 v Apr to Jul 2015

	Cost/Wtd Patient		
	2016/17	**2015/16**	**% Growth**
Angus IJB	£72.04	£68.79	4.72%
Dundee IJB	£68.71	£66.93	2.62%
Perth & Kinross IJB	£69.05	£65.61	5.24%
Tayside	£70.73	£68.01	4.00%
Scotland	£65.33	£62.98	3.73%

NHS Tayside's cost per weighted patient has increased by 4%, compared with a Scotland-wide increase of 3.7% for the same period. Whilst the gap to the Scottish average remains significant at 8.3%, a worsening of the position is seen from the closing months of last financial year. On an annual basis the variation financially extends to close to £7 million. More recently collaboration has commenced with both Ayrshire & Arran and Fife Health Boards.

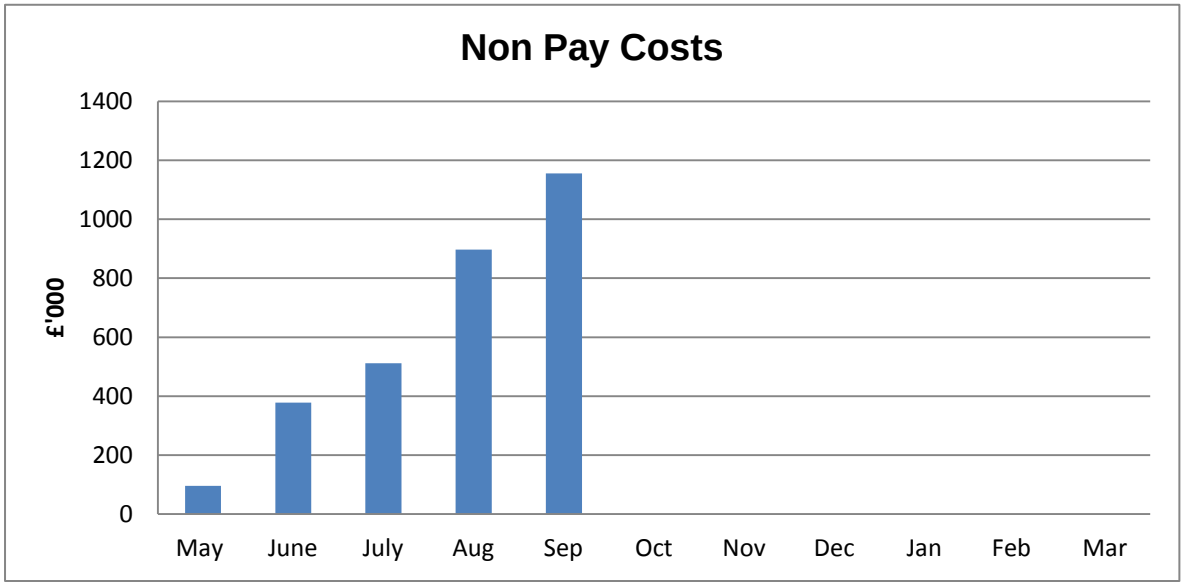
Hospital & Community medicine spend continues to live within the resources available albeit in month the spend within the Medicine Group increased by in excess of £700k (47%) greater than had been seen in the year to date. The spend relates in particular to Hepatitis C and rheumatology. Whilst an increase cost in the month for Hepatitis C the team responsible will still remain within the resources determined at the start of the year and in line with Scottish Government targets. Closer working will be required to ensure the profile to year end is known. It is recognised there has been a transformation in treatment regimes since the introduction of new medicines over a year ago with a variety of retrospective rebates available. The rebate is planned for but given the fast moving environment it will be checked that this remains reasonable.

3.6 Non Pay Costs

Table 8 – Non Pay Costs

Non Pay	Annual Plan	Plan to Date	Actual to Date	Over/ Under(-)
	£000s	£000s	£000s	£000s
Clinical Supplies	56,859	28,969	30,420	1,451
Energy Costs	10,571	4,641	4,497	-144
Other Supplies & Services	95,525	38,444	38,292	-152
Total	162,955	72,054	73,209	1,155

Chart 3



The benefits from the national pricing scheme are apparent within energy.

Demand pressures continue to impact on the level of clinical supplies costs consumed with the Workstream Programme ensuring that optimum products are procured and at the most economically beneficial price. The focus of the Facilities and Estates workstream will also derive benefit as each of the individual initiatives gains traction.

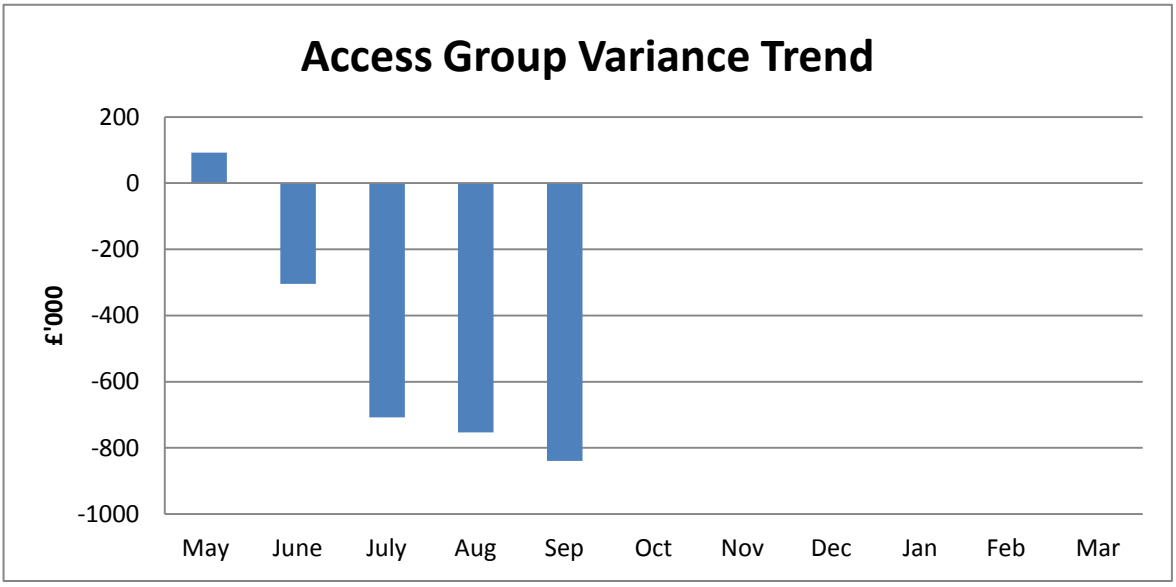
3.7 Group Summary

Access Group

Table 9 – Operating Costs for the period to 30 September, 2016

Service	Annual Budget £m	Budget to 30.09.16 £m	Actual to 30.09.16 £m	Variance £m
Access Management Team	0.495	0.247	0.236	-0.011
Diagnostics	39.599	20.351	20.183	-0.168
H.A.I.	1.150	.581	.548	-0.034
Hosted Services	10.718	5.395	5.393	-0.001
Dental	8.652	4.331	3.834	-0.497
Pharmacy	11.025	5.595	5.466	-0.129
Total	**71.638**	**36.500**	**35.660**	**-0.839**

Chart 4



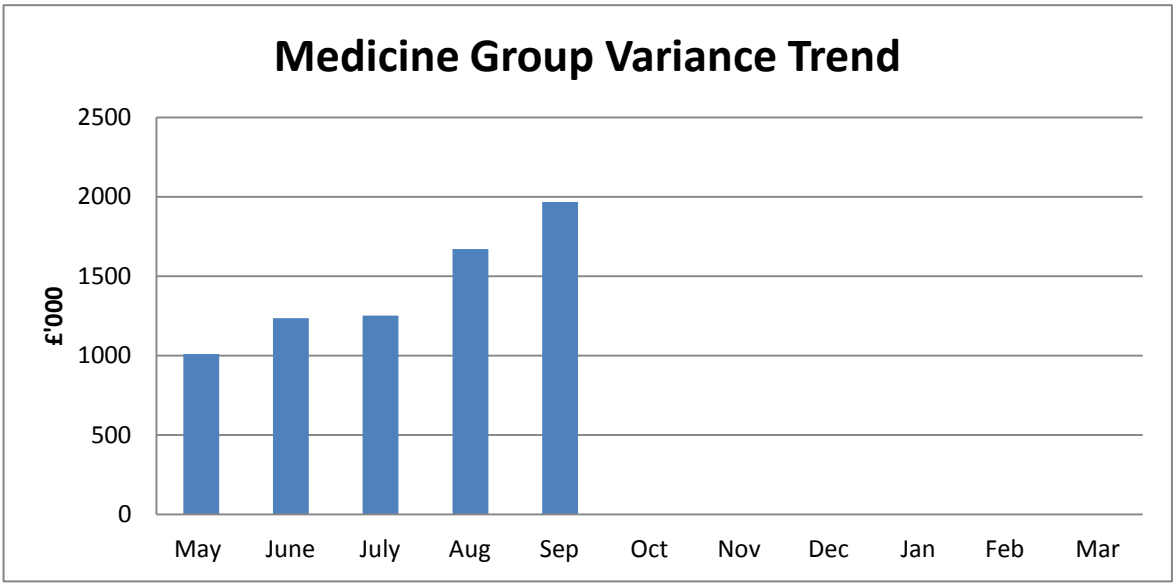
- The position within Access is supported through staff turnover and vacancies.
- Recent vacancies across the Directorate have now been filled and in particular within Radiology where both consultant radiologist and radiographers have commenced and also within Laboratories.
- The iFit medical records tracking system has been implemented, and, whilst identifying a net cost at this stage of the year due to the procurement costs, this will readily be clawed back through the revised staffing levels and will deliver a recurring savings benefit.

Medicine Group

Table 10 – Operating Costs for the period to 30 September, 2016

Service	Annual Budget £m	Budget to 30.09.16 £m	Actual to 30.09.16 £m	Variance £m
Planned Care	40.216	20.807	22.233	1.426
Urgent Care	30.916	15.610	16.368	0.758
Women & Children Services	47.516	23.841	23.646	-0.195
Medicine Other	0.225	0.118	0.097	-0.021
Total	**118.873**	**60.376**	**62.344**	**1.968**

Chart 5



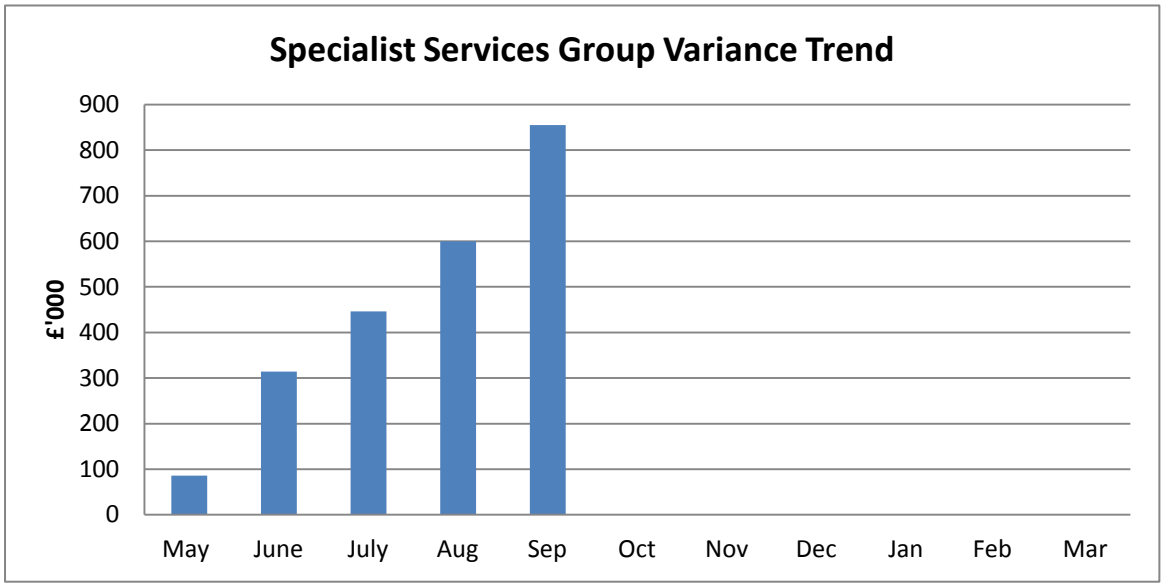
- Since April the service has continued to staff the acute surge beds across the medicine floor, and is reporting an overspend of £0.5 million at the end of September.
- Absence levels overall within the Group for the year to date are identified as 4.56%, although inevitably a small number of individual areas are reporting considerably higher levels. Higher absence, together with vacancies, continues to drive a level of supplementary and agency costs. Agency costs show a minor increase of £16k in comparison with the same period last year but remain significant at close to £1.6m for the six-month period. This equates to an average of 28 wte.
- Costs were incurred for a previously breached medical training grade rota. Whilst compliant, the additional costs were maintained until the changeover in August. The additional costs incurred total £0.2m.
- eRrostering has been rolled out across 19 wards with further roll out in the forthcoming months. This will facilitate the provision of more robust data to ensure the effective deployment of the workforce resource.
- Prescribing opportunities have been implemented through the use of biosimilars and continue to contain spend.
- A profile on intended Hep C spend is to be obtained in order to inform future months spend patterns.

Specialist Services

Table 11 – Operating Costs for the period to 30 September, 2016

Service	Annual Budget £m	Budget to 30.09.16 £m	Actual to 30.09.16 £m	Variance £m
Specialist Services	45.075	22.311	22.763	0.452
Oncology, Haematology & Renal	23.676	12.045	12.462	0.417
Specialist Services Other	0.533	0.266	0.252	-0.015
Total	**69.284**	**34.623**	**35.477**	**0.854**

Chart 6



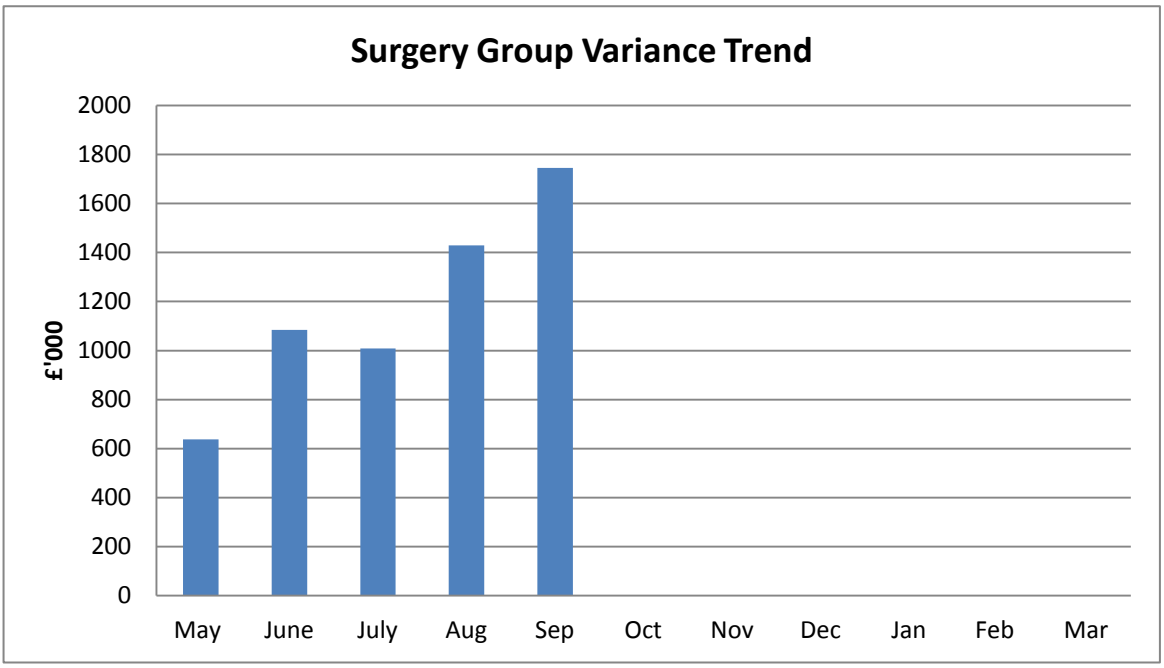
- A proleptic appointment within Ophthalmology contributes to the financial position of the Group.
- The impact of posts previously supported through other funding mechanisms continues to impact.
- Ten Specialist Services wards have been rolled out onto the eRostering system, with oncology and renal services currently being implemented.
- Supplementary costs continue at a relatively low level for the Group which, at £391k to date, is £165k below the previous year level.
- The impact of new drug regimes can be significant within this Group and continues to be closely monitored.

Surgery

Table 12 – Operating Costs for the period to 30 September, 2016

Service	Annual Budget £m	Budget to 30.09.16 £m	Actual to 30.09.16 £m	Variance £m
General Surgery	28.839	14.658	15.471	0.812
Orthopaedics	21.886	11.048	10.874	-0.174
Theatres and Critical Care	36.939	19.222	20.478	1.255
Surgery Other	0.702	0.339	0.189	-0.150
Total	**88.367**	**45.267**	**47.012**	**1.744**

Chart 7



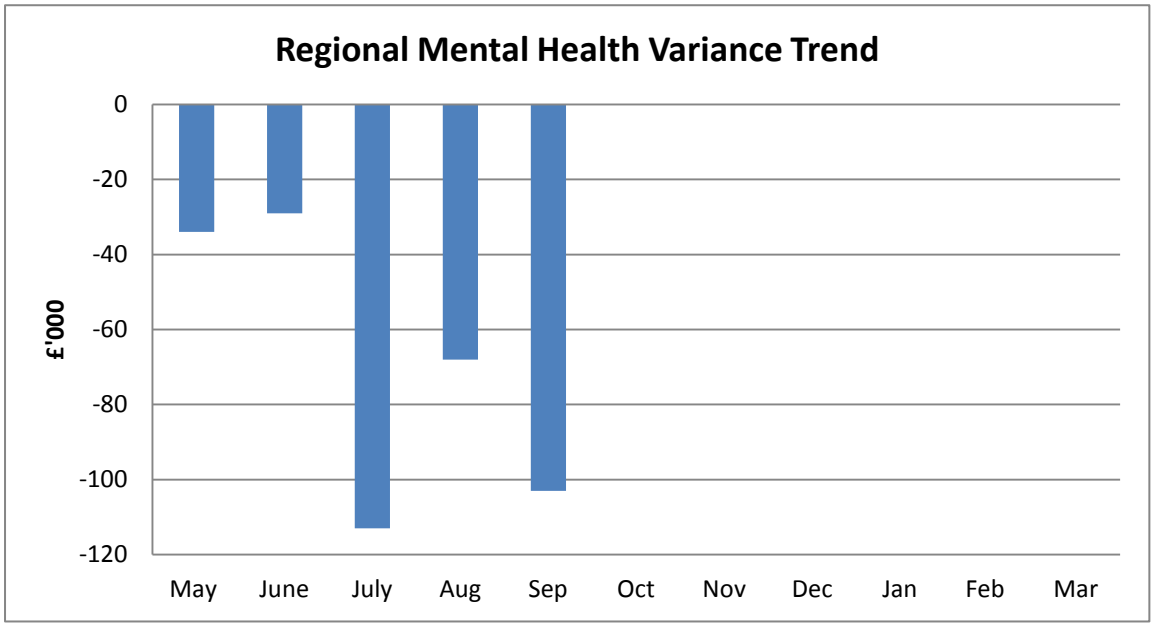
- Non compliant medical rotas contribute to the position shown. Approximately £180k has been incurred to date. One rota is compliant from August, with options to reduce costs associated with a second rota being considered.
- High levels of maternity leave in Critical Care continue to drive the cost base with absence levels, particularly with Orthopaedics and Theatres driving the levels of supplementary staffing. Absence levels are in excess of 5.0% for both, with the Group as a whole sitting at 4.3%. Supplementary costs at close to £2.1 million, however, are close to £300k below the previous year level.
- All Orthopaedic and General Surgery wards have been rolled out onto the eRostering system, together with the four Critical Care units.
- Winter surge beds have contributed £64k to the costs of the Group, with those beds having now been retracted.
- A review of the Orthopaedic wards has resulted in redesign, which is currently in the process of implementation.
- Prescribing costs at present are contained within the budgetary limits with potential for cost reductions through the elimination of waste and increased efficiency across the wards.

Regional Mental Health

Table 13 – Operating Costs for the period to 30 September, 2016

Service	Annual Budget £m	Budget to 30.09.16 £m	Actual to 30.09.16 £m	Variance £m
Forensic Services	5.251	2.630	2.395	-0.235
Other Services	1.169	0.647	0.716	0.068
Centrally Managed Budget	-0.171	-0.064	0.000	0.064
Total	**6.249**	**3.214**	**3.110**	**-0.104**

Chart 8



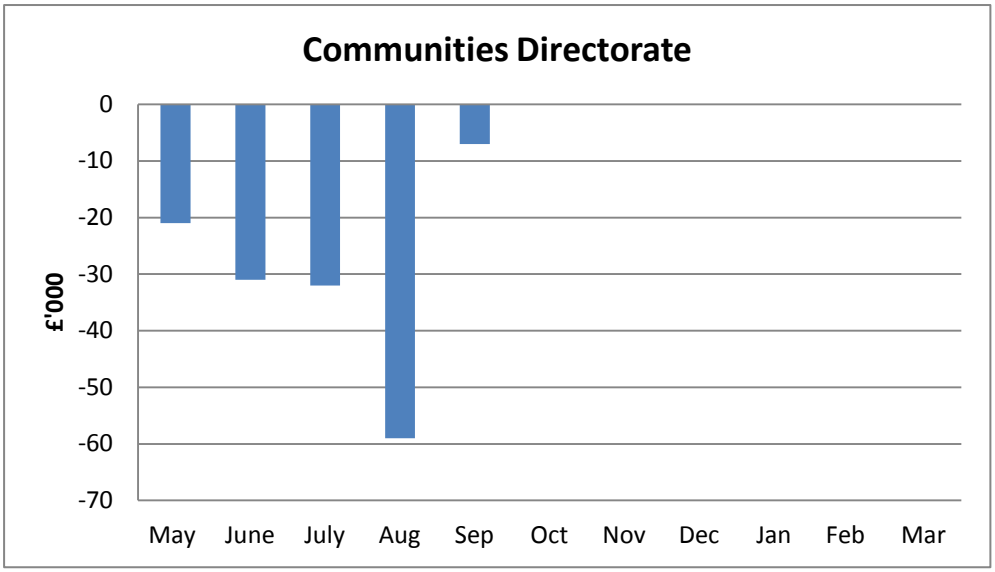
- Agency cover totalling £327k has been incurred in the six-month period, principally in relation to training grade medical staff and the challenges that have been highlighted in levels of staffing. The first quarter incurred 75% of these costs.
- Supplementary costs (excluding Agency) are relatively small for this group at £187k with £138k incurred in relation to overtime. The premium impact of overtime equates to £46k.

Tayside Communities

Table 14 – Operating Costs for the period to 30 September, 2016

Service	Annual Budget £m	Budget to 30.09.16 £m	Actual to 30.09.16 £m	Variance £m
Children & Young People	11.832	6.072	5.982	-0.090
Primary Care	0.022	-0.024	-0.087	-0.064
Primary & Community Reserves	0.911	-0.146	0.000	0.146
Total	**12.766**	**5.902**	**5.895**	**-0.007**

Chart 9



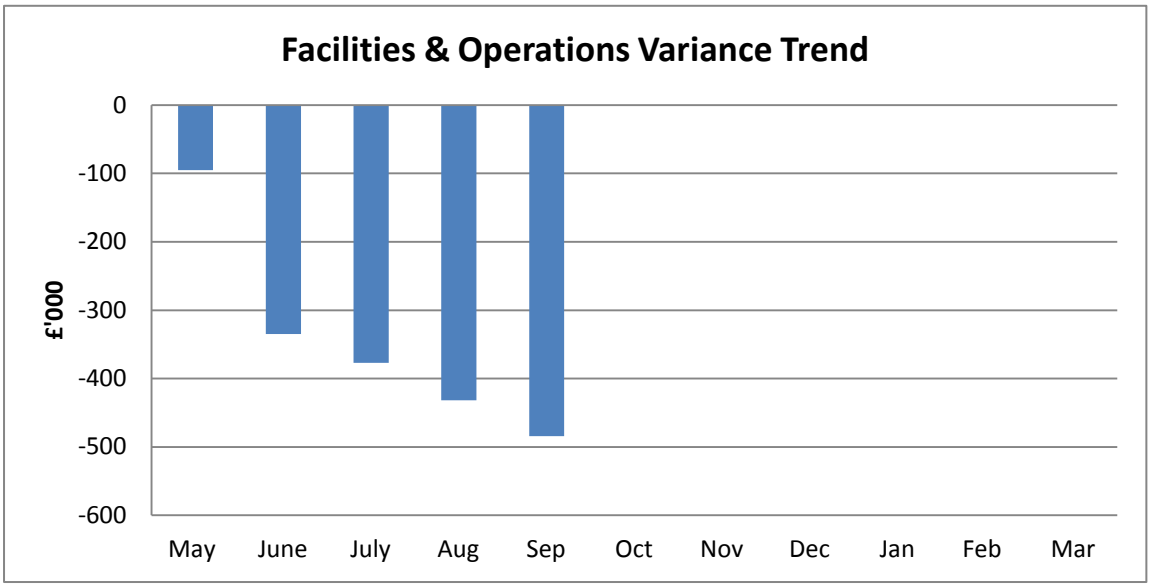
- Supplementary costs are minimal for this area.
- Vaccine costs remain within the identified financial budgetary limit.

Facilities & Operations

Table 15 – Operating Costs for the period to 30 September, 2016

Service	Annual Budget £m	Budget to 30.09.16 £m	Actual to 30.09.16 £m	Variance £m
Property	40.026	19.717	19.242	-0.475
Site Support Services	29.057	14.236	14.258	0.022
Procurement	1.196	.580	.554	-0.026
Production Unit	2.273	1.227	1.206	-0.021
Tayside Pharmaceuticals	-0.157	-0.368	-0.384	-0.016
General Management	1.624	0.921	0.953	0.032
Total	**74.019**	**36.313**	**35.829**	**-0.484**

Chart 10



- Energy price negotiations through the National Procurement Framework have seen a significant reduction in the unit price for gas. This equates to approximately a 30% reduction.
- Property services has commissioned an external consultant to review waste and variation within utility charges across Tayside, with an indication that clawback will be obtained of c£0.5 million, together with a small recurring benefit.
- Central Legal Office costs continue to increase, reflecting the level of activity across the principal areas of contact with the centralised function.
- Agency costs have virtually been eliminated from this Group.
- The premium impact of overtime equates to £108k

Integrated Joint Boards (IJBs)

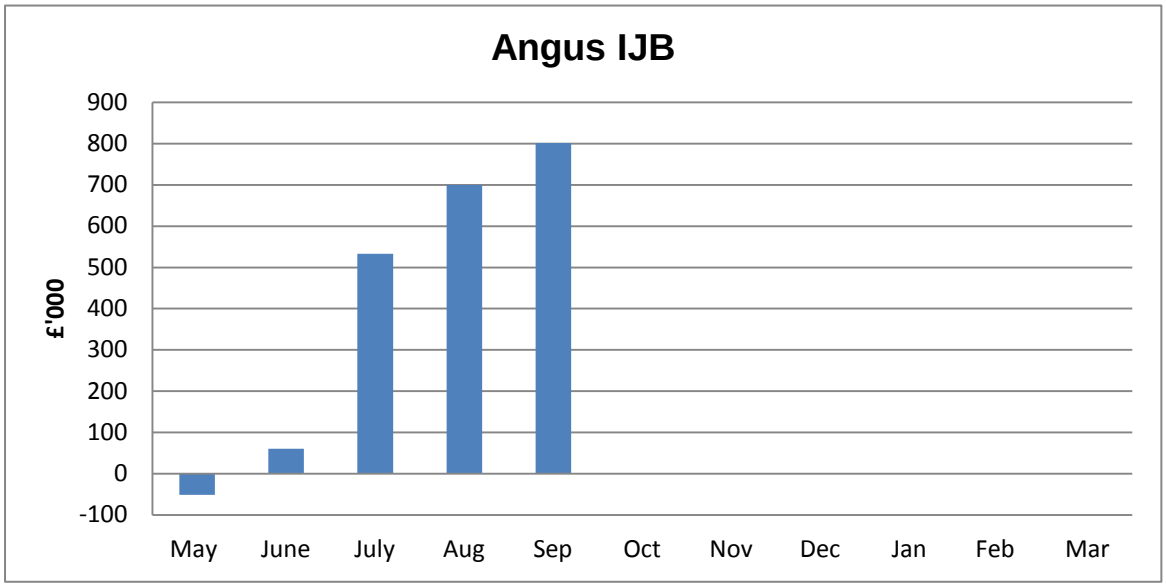
The positions identified for the three IJBs reflect the cross charging for services presently hosted within each of the bodies. A standard split is in place across each of the three bodies. This sees a sharing of any reported over/underspend for each Hosted function.

Angus IJB

Table 16 – Operating Costs for the period to 30 September, 2016

Service	Annual Budget £m	Budget to 30.09.16 £m	Actual to 30.09.16 £m	Variance £m
Core Revenue - Pay & Supplies	40.076	18.010	17.388	-0.622
Core Revenue - FHS Prescribing	20.840	10.496	11.706	1.210
Core Revenue - Hosted Services	15.639	7.973	8.219	0.245
General Medical Services	16.420	8.248	8.229	-0.019
FHS Cash Ltd & Non Cash Ltd	11.461	5.737	5.722	0.000
Total	**104.436**	**50.464**	**51.265**	**0.801**

Chart 11



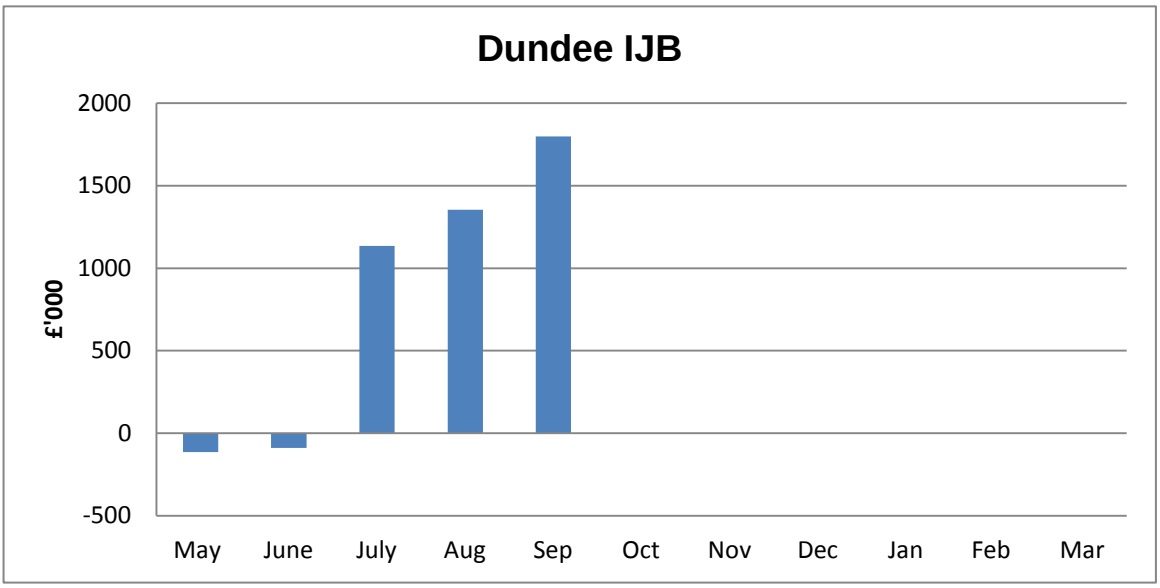
- Angus IJB considered the devolved budget and range of proposed savings measures and work programmes at its meeting on 29 June, 2016.
- A risk around the delivery of the devolved GP Prescribing Budget has been reported.
- A Prescribing Management Group (PMG) has been established at a Tayside level comprising clinical, financial and managerial input from Clinical Groups and IJBs, and supported by corporate Pharmacy and Financial colleagues. The PMG will be supported by prescribing/medicines forums in each of the partnerships/secondary care. Delivery of actions will be supported by a Prescribing Support network.
- Risks are also identified in relation to the Forensic Medical Service with particular regard to medical staffing.

Dundee IJB

Table 17 – Operating Costs for the period to 30 September, 2016

Service	Annual Budget £m	Budget to 30.09.16 £m	Actual to 30.09.16 £m	Variance £m
Core Revenue - Pay & Supplies	53.304	23.895	24.412	0.517
Core Revenue - FHS Prescribing	33.234	16.735	17.778	1.043
Core Revenue - Hosted Services	22.877	11.653	11.948	0.296
General Medical Services	24.629	12.372	12.344	-0.028
FHS Cash Ltd & Non Cash Ltd	20.169	10.075	10.046	-0.029
Total	**154.213**	**74.729**	**76.526**	**1.797**

Chart 12



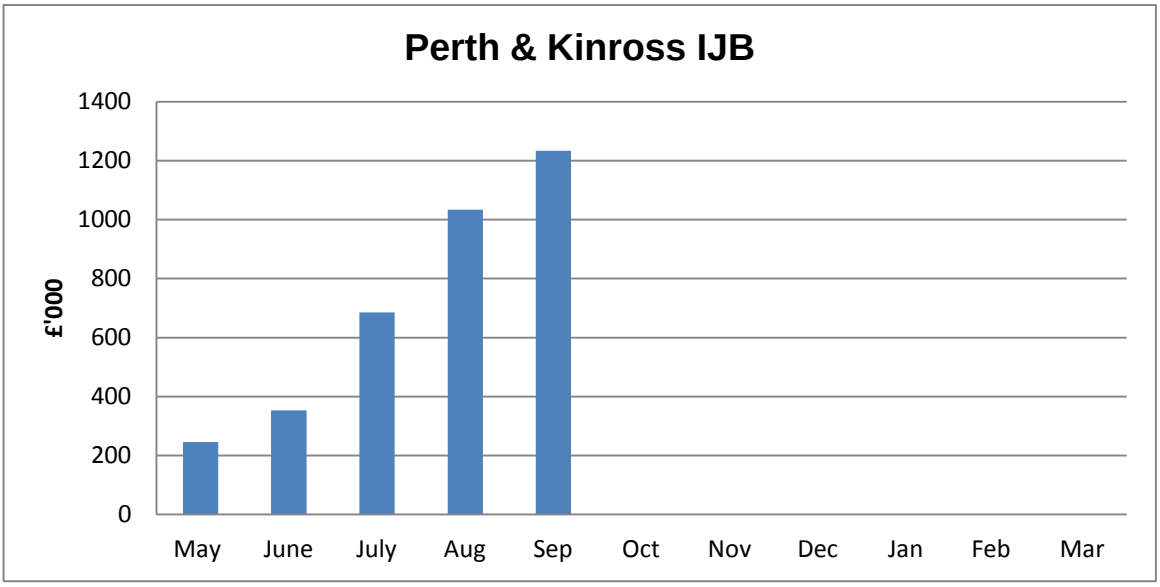
- Dundee IJB considered the devolved budget and range of proposed savings measures and work programmes at its meeting on 28 June, 2016.
- A risk around the delivery of the devolved GP Prescribing Budget has been reported with the stated intention of invoking the risk sharing agreement.
- The due diligence and transfer of resources in for the Medicine for the Elderly budgets for nursing and admin has been completed. The resource in relation to medical staffing has not been finalised.

Perth & Kinross IJB

Table 18 – Operating Costs for the period to 30 September, 2016

Service	Annual Budget £m	Budget to 30.09.16 £m	Actual to 30.09.16 £m	Variance £m
Core Revenue - Pay & Supplies	42.225	19.274	19.609	0.335
Core Revenue - FHS Prescribing	26.155	13.161	14.070	0.909
Core Revenue - Hosted Services	19.879	10.129	10.160	0.031
General Medical Services	22.103	11.103	11.078	-0.025
FHS Cash Ltd & Non Cash Ltd	13.473	6.755	6.738	-0.017
Total	**123.836**	**60.422**	**61.656**	**1.234**

Chart 13



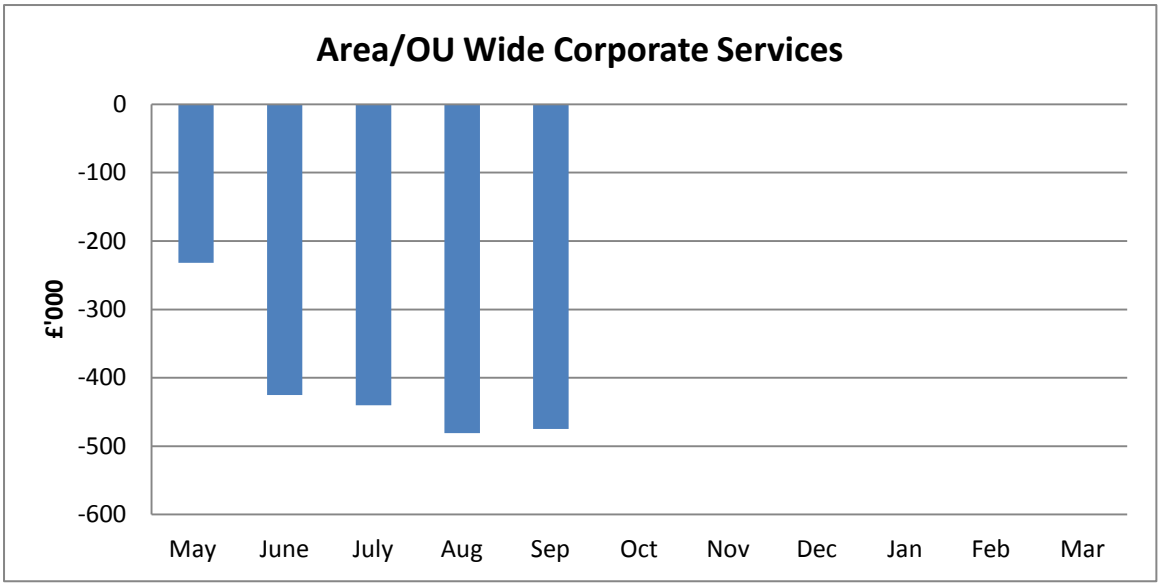
- Perth & Kinross IJB considered the devolved budget and the work undertaken by the Chief Finance Officer and wider partnership team to develop a robust financial recovery plan.
- In a similar vein to the other IJBs, noted the risk around the delivery of the devolved GP Prescribing budget.
- In addition, the IJB noted the significant financial risk which remains to the use of supplementary staffing across a number of directly delegated services and the progress being made to manage this risk in 2016/17 and future years.
- High locum spend in both General Adult Psychiatry and Learning Disability continues recognising recruitment challenges. This is not expected to be resolved in the short term.

Area/OU Wide Corporate Services

Table 19 – Operating Costs for the period to 30 September, 2016

Service	Annual Budget £m	Budget to 30.09.16 £m	Actual to 30.09.16 £m	Variance £m
Public Health/Health Promotion	5.269	2.566	2.508	-0.058
Drug and Alcohol Teams	1.662	0.900	0.900	0.000
Medical Education	0.265	0.133	0.129	-0.004
Finance	8.359	3.983	3.798	-0.185
eHealth	10.948	5.023	5.379	0.356
Human Resources	5.383	2.835	2.800	-0.035
Pharmacy	0.329	0.132	0.134	0.002
Board Corporate	5.676	2.617	2.475	-0.157
Corporate Earmarks	2.242	-1.971	-2.110	-0.139
Corporate Medical & Nursing	5.264	2.930	2.712	-0.218
Other Corporate	6.471	5.246	5.199	-0.047
North of Scotland Planning Group	0.937	0.479	0.479	0.000
Total	**52.805**	**24.886**	**24.411**	**-0.475**

Chart 14



- WTE Worked has fallen by 27 since the start of the financial year.

3.8 Efficiency Savings

In submitting an unbalanced Local Delivery Plan to SGHSCD at the end of May 2016, cognisance was given to the in year delivery of what were regarded as high risk initiatives. The risk recognised both the ability to deliver in the anticipated timescale and also the ability to deliver on the monthly anticipated financial efficiency.

Whilst the core workstream programme was initially considered on a NHS Tayside basis, it now recognises the delegation of resources to the IJBs who, in considering the mechanisms to deliver on the overall efficiency devolved, were free to consider any actions that contained spend patterns. The ability to participate in the workstream programme is, however, not excluded and is indeed welcomed.

The position against the workstream programme is depicted below, together with the position of the IJBs in order to provide a NHS Tayside perspective.

Table 20 – Efficiency Savings

Workstream/Intitiative	Annual Plan	Revised 2016/17 Plan LDP Submission	Plan to Sep (excl IJB)	Achieved to Sep	Unachieved Savings to Sep
	£'000	£'000	£'000	£'000	£'000
Service Redesign	2,000	1,300	0	0	0
Facilities & Estates	2,000	2,000	802	687	115
Better Buying & Procurement	1,750	1,750	809	773	36
Workforce	17,000	14,900	5,086	4,608	478
Realistic Medicine	10,050	7,250	1,275	1,447	-172
Operational Efficiencies	1,000	1,000	338	265	73
Repatriation	1,500	1,500	375	0	375
Alcohol & Drugs	600	300	150	0	150
Corporate	12,000	12,250	6,100	6,000	100
National Initiatives	10,500	0			
Asset Disposal Proceeds		4,500	254	254	0
Total Workstreams	**58,400**	**46,750**	**15,189**	**14,034**	**1,155**
			Plan to Sep IJB	**Achieved to Sep**	**Unachieved Savings to Sep**
Integrated Joint Boards			2,640	1,908	732
Total Efficiencies	**58,400**	**46,750**	**17,829**	**15,942**	**1,887**
Shortfall Against Original Plan Per LDP Submission		**11,650**			

At this stage of the year a shortfall of £1.887 million is identified against the required efficiencies with the main areas relating to efficiencies within rostering and within FHS Prescribing. The effective deployment of staff and management of time out remain instrumental in driving the efficiencies identified within the workforce and care assurance programme, with data from both the eRostering and Safecare systems providing the impetus and the robustness of challenge to inform actions that will secure future efficiencies.

A Prescribing Management Group (PMG) has been established at a Tayside level comprising clinical, financial and managerial input from Clinical Groups and IJBs, and supported by corporate Pharmacy and Financial colleagues. The PMG will be supported by prescribing/medicines forums in each of the partnerships/secondary care. Delivery of actions will be supported by a Prescribing Support network. Recent collaboration with both Ayrshire & Arran and Fife Health Boards will also be extended.

A range of further accelerated initiatives are presently being considered/initiated that will see a further reduction on spend patterns that have been experienced in the first half of the year. The intention of these initiatives is to ensure delivery of the efficiency savings target in full by year end.

The impact of initiatives implemented is not solely on 2016/17 as the Financial Framework sets out a target of 40% of efficiency savings to be delivered on a recurring basis. The assessment of the programme will also bring this aspect into focus as this will inform the efficiency savings delivery requirement for 2017/18.

The progress of the workstreams is monitored though the Transformation Programme Board.

3.9 Board Committed Earmarks

The financial plan provides for £22.5 million to meet deferred expenditure carried forward from 2015/16. The actual level of deferred expenditure at March 2016 totalled £25.7 million. Savings required from expenditure brought forward is, therefore, £3.2 million.

The bulk of the deferred expenditure target is met from specific SGHSCD allocations received in 2016/17, which will be expended in 2017/18. There is normally an unavoidable timing difference between the receipt of an SGHSCD allocation and expenditure being incurred, due to the necessary inter-agency consultation and the governance approvals process.

The March 2017 deferred expenditure target is £23.5 million. At this stage, the main risk to delivery of this target is the re-routing of central partnership funding through IJBs to Local Authorities. These funds would previously have been hosted by NHS Tayside, with inherent delays in the use of funds contributing towards the deferred spend target. The issue is currently being worked through with IJB Chief Finance Officers.

3.10 Forecast Outturn

The focus of the organisation remains on delivering a position that minimises the shortfall on resources at year end with the outer limit reflecting the unbalanced LDP submitted in May to SGHSCD. In recognising this, the Board has responded through the development of a range of accelerated efficiency proposals for consideration and adoption. Assessments on the Forecast Outturn at an individual Group/Service Area level continue to be developed and refined, recognising the current spend patterns and those initiatives that are presently in place.

3.11 Board Contingency

The financial plan approved by the Board provided a contingency for 2016/17 of £4.3 million. Of this resource, £1.3 million is set aside to respond to environmental issues with a general contingency of £3.0 million.

At this stage of the year £1.5 million has been provisionally released to recognise in particular the costs of the surge beds that have remained open and also the additional costs of "hard to recruit to" medical posts and non compliant medical rotas.

3.12 Reconciliation to Approved Financial Plan

A reconciliation of anticipated resources per the approved financial plan to the updated position at 30 September, 2016, is included in Table 21. The variation on anticipated allocations received to date is entirely related to ring fenced earmarks.

Table 21 – Reconciliation of Total Resources as at 30 September, 2016

	Core RRL	Non Core RRL	Non Discretionary	Total Resources
	£'000	**£'000**	**£'000**	**£'000**
Approved Financial Plan	**777,421**	**31,930**	**42,642**	**851,993**
Variations on anticipated allocations	4,570			4,570
Revision to Non-discretionary				0
Revision to Non Core		-630		-630
Total Resources at 30 September, 2016	**781,991**	**31,300**	**42,642**	**855,933**

3.13 Cash Requirement

The cash requirement, which is one of the statutory targets the Board is required to meet, is the financing requirement to fund the cash consequences of the ongoing operations and net capital investment. SGHSCD has not yet set the cash requirement target for NHS Boards.

4. MEASURES FOR IMPROVEMENT

Efficiency improvements are reported in paragraph 3.8. Other measures are noted in the risk assessment attached at Appendix 2, which focuses on Year 1 of the Financial Framework.

5. RESOURCE IMPLICATIONS

Financial
Financial implications are advised throughout this report.

Workforce
Workforce implications are managed at both a strategic and operational level, consistent with the Board's plans.

6. DELEGATION LIMIT

Not applicable.

7. IMPLICATIONS FOR HEALTH

As ever, there is a requirement to balance service demand with resource availability.

8. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

SGHSCD financial monitoring returns for the period to 30 September, 2016, were submitted to SGHSCD on 19 October, 2016.

The lead officer is the Chief Executive in her role as Accountable Officer, with support from Directors, and specifically the Director of Finance.

9. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

Board and Integrated Joint Board reports and returns have been used in the compilation of this report. Wider engagement opportunities have been initiated with the clinical fraternity and senior management groups on the Board's financial framework and associated challenges and opportunities.

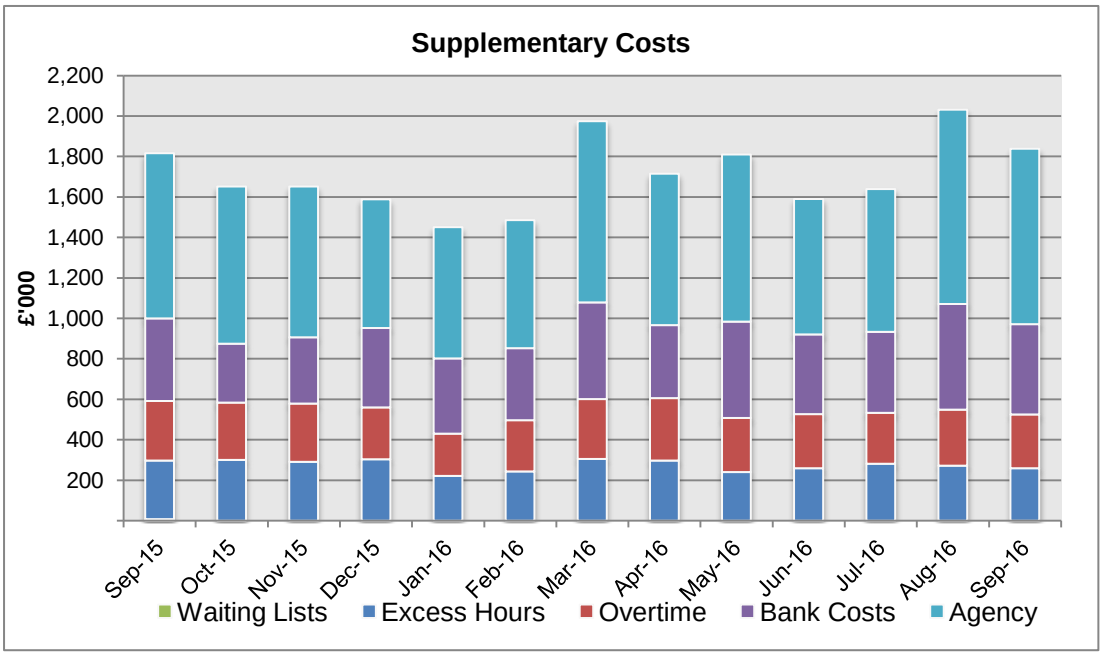
10. EQUALITY & DIVERSITY IMPACT ASSESSMENT

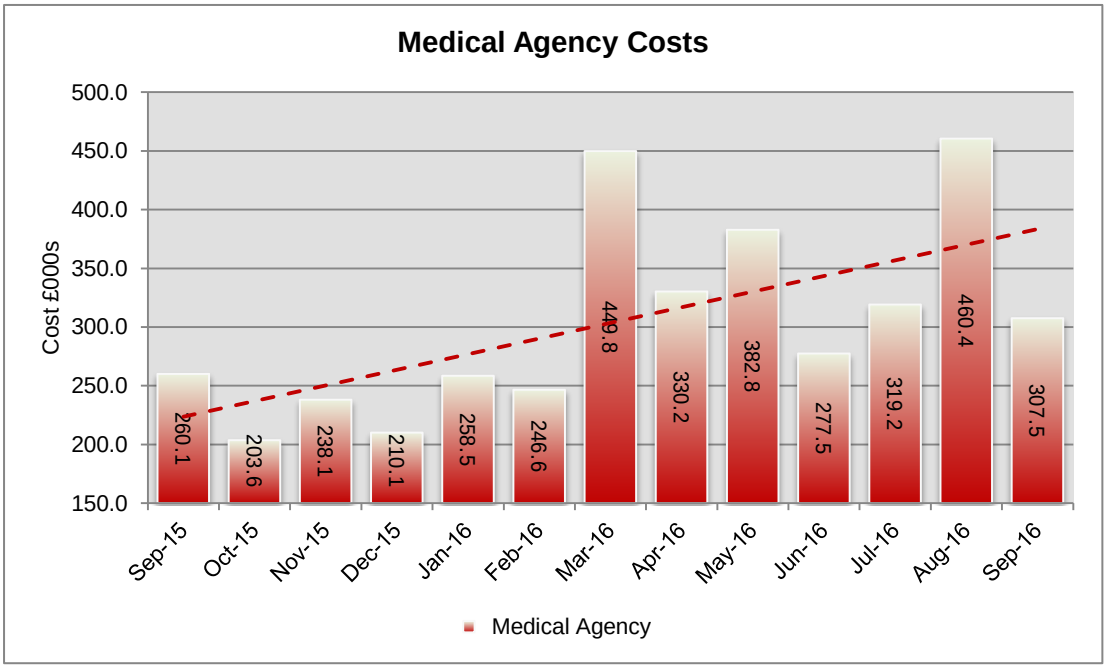
The equality and diversity impact is considered as part of each business case.

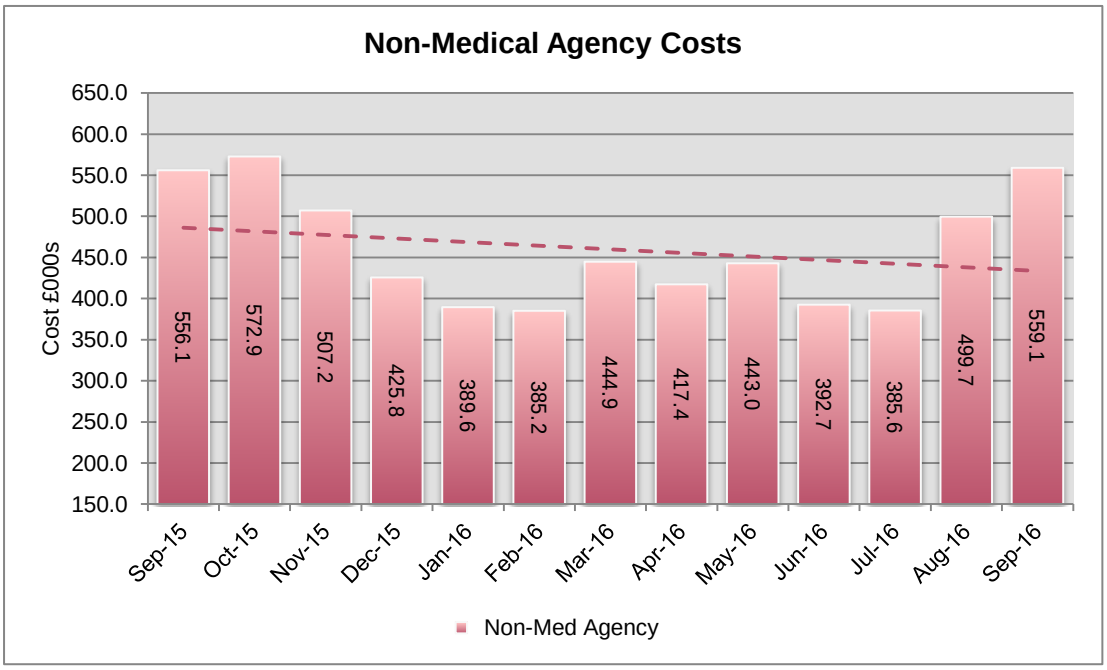
11. PATIENT EXPERIENCE

Contributes to the delivery of care and services across a range of environments in NHS Tayside. As part of the engagement programme highlighted above, a wider dialogue with both patients staff and public will be initiated.

Mr S Lyall **Head of Finance** **October 2016**	**Mr L Bedford** **Director of Finance**	**Ms L McLay** **Chief Executive**


Supplementary Costs
£'000
2,200
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Waiting Lists
Excess Hours
Overtime
Bank Costs
Agency


Medical Agency Costs
Cost £000s
500.0
450.0
400.0
350.0
300.0
250.0
200.0
150.0
260.1
203.6
238.1
210.1
258.5
246.6
449.8
330.2
382.8
277.5
319.2
460.4
307.5
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Medical Agency


Non-Medical Agency Costs
Cost £000s
650.0
600.0
550.0
500.0
450.0
400.0
350.0
300.0
250.0
200.0
150.0
556.1
572.9
507.2
425.8
389.6
385.2
444.9
417.4
443.0
392.7
385.6
499.7
559.1
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Non-Med Agency

RISK ASSESSMENT 2016/17 **Appendix 2**

Risks – Revenue	Risk Assessment		Risk Management/Comment
	Likelihood	Impact	
Cost reduction target of £46.75m (net of LDP deficit) for 2016/17 not achieved in full.	High	**Up to £7m**	Strategic Transformation Programme Board (STPB) established to provide a governance and reporting framework for monitoring of the workstream programme and wider cost reduction plans. Accelerated initiatives being considered/adopted/implemented
Recurring savings achievement falls short of financial plan assumptions.	High	**Up to £4.0m**	Current Strategic Financial Plan (SFP) assumes 40% recurring savings achievement in 2016/17.
Medicines cost and volume increases higher than planned.	High	Up to £3.0m	SFP provides for an uplift of £6.0m for FHS Prescribing; £2.7m for Secondary Care. Efficiency Programme supported through the Realistic Medicine Workstream. Availability of £4.6m New Medicines Fund from SGHSCD.
Activity growth, patient acuity levels, or service pressures greater than anticipated.	High	**Up to £6.0m**	Position subject to ongoing review, with implementation of revised efficiency plans where necessary.
Reliance on supplementary staffing continues at current levels.	High	Up to £2.0m	Initiatives to reduce premium rate staffing costs initiated through the Workforce & Care Assurance Workstream. Real-time RAG status reporting developed to ensure effective deployment of overall Nursing resource. Centralised Rostering Bureau. eRostering roll-out.
Delayed Discharges remain within the hospital system, thereby inhibiting bed re-profiling and patient flow, and impacting on TTG targets through cancellation of elective activity.	High	Up to £2.0m	£11m Social Care and Delayed Discharge funding allocated to IJBs.
Profit on disposal of assets – the timing and amount of asset disposal proceeds is unpredictable.	High	Up to £2.0m	Framework for delivery supported through workstream programme.
Enhancements During Leave – backdated payments may exceed the amount accrued through 2015/16 accounts.	Medium	Up to £1.0m	Ongoing monitoring and review.
SGHSCD anticipated funding allocations may be less than anticipated through financial plans.	Medium	Up to £1.0m	Ongoing monitoring and review.
Environmental control risk (Mental Health) – cost of property upgrades exceeds contingency.	Medium	Up to £1.0m	Ongoing monitoring and review.
Funding sources assumed within the 2016/17 efficiency plan not available (Non DEL, NPDO refinancing).	Medium	Up to £4.0m	SGHSCD Finance have advised that Non DEL monies will be available to Boards next year – amount to be confirmed.
Costs incurred following approval of new medicines nationally are not contained within the overall prescribing uplift.	Medium	Not quantified	Allocation of £4.6m anticipated through SGHSCD New Medicines Fund. Position kept under review by the Medicines Management Group following SMC approval of drugs.
The source of planned carry forward and deferred expenditure at March 2017 (£22.5m) uncertain at this stage.	Medium	Up to £2.0m	The SFP reduces the planned level of deferred spend by £1.0m from the previous year.
Inability to mitigate costs in line with reductions in anticipated central funding allocations, including Outcomes Framework and Alcohol & Drugs funding.	Medium	c£1.0m	Implications recognized within SFP. Current and future commitments subject to review.
Costs for healthcare provided through other NHS Boards higher than planned.	Medium	Up to £0.75m	Additional £0.9m funding allocated through SFP in 2016/17. Patient activity trends closely monitored.
Cost of planned developments higher than anticipated.	Medium	Up to £0.5m	Slippage in implementation often results in a non-recurring saving.
Price inflation may be higher than the planned level of 1.5%.	Low	Up to £0.2m	The allowance of 1.5% is consistent with provisions made by other NHS Boards.
Income from other Boards reduces as a result of planned service reconfiguration.	Low	c£0.5m	Early engagement with partner Health Boards to understand implications of service moves.

Risks – Revenue	Risk Assessment		Risk Management/Comment
	Likelihood	Impact	
Equal Pay claims exceed anticipated amount.	Low	Up to £0.1m	Accrual recognised within 2015/16 accounts.
Costs associated with Healthcare Infection Standards greater than planned.	Low	£0.2m	Position monitored.

Archived Risks

Repayment of financial brokerage due from 2015/16 not made.	High	Not quantified	Amount of brokerage from 2015/16 and related profile of repayments to be agreed with SGHSCD Director of Finance.
Loss of income from Special Boards (NSS, NES, NSD).	Medium	Up to £0.5m	Projects funded from this income will require review.
Cost of meeting National Performance Targets exceeds available funding.	High	Up to £2.0m	Profile agreed with Access Support Team
Pay award settlements higher than anticipated.	Low	Up to £0.5m	Pay Awards for AfCstaff and Medical/Dental paid
Higher than anticipated numbers of staff remain in the pension scheme following automatic re-enrolment.	Low	Up to £0.5m	No significant impact

Item 8.3

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

BOARD109/2016
Tayside NHS Board
27 October 2016

TAYSIDE NHS BOARD PERFORMANCE REPORT

Ms L Wiggin
Chief Operating Officer

Ms L McLay
Chief Executive

Dr A Cook
Medical Director – Operational Unit

October 2016

NHS Tayside

Board Performance Report
to August 2016

Lorna Wiggin
Director of Acute Services
NHS Tayside

Alan Cook
Operational Medical Director
NHS Tayside

Lesley McLay
Chief Executive
NHS Tayside

CONTENTS

	Page
1. Access	3 - 11
2. Efficiency	12 - 20
3. Patient Safety	21 - 24
4. Data Quality	25 - 26
5. Feedback and Complaints	27 - 28
6. Unscheduled Care Measurement	29 - 31

Measure	Definition	Data Source	Data Validation	Time Period Reported
Treatment Time Guarantee (TTG)/ Stage of Treatment (SOT)	*Inpatient/Daycases (Treatment Time Guarantee):* Treated and waited more than the 84 days - Measures the number of inpatient/daycase patients who were treated and had waited over 84 days from the clock start date to the date of admission. Waiting > 84 days TTG target as at month end - Measures the number of patients on the inpatient/daycase waiting list waiting over 84 days from the clock start date to the census date (month end) (Removals by patient or Hospital from the waiting list are not included) *Outpatients:* Measures the number of patients on the Outpatient waiting list waiting over 12 weeks from the clock start date to the census date (month end), (including cases with unavailability) as at the month end. Percentage of New Outpatients waiting < 12 weeks as at month end (includes unavailable patients) as at the month end. Number of New Outpatient waiting over 16 weeks as at the month end (includes unavailable patients). *Diagnostics:* Measures the number of patients waiting over 6 weeks for one of 8 key diagnostic tests from the clock start date to the census date (month end). Diagnostic tests include; upper endoscopy, lower endoscopy, Cystoscopy, colonoscopy, MRI, CT, non-obstetric ultrasound, barium studies. Rankings are displayed to compare our performance with that of the 10 other territorial boards (namely, Ayrshire & Arran, Boarders, Dumfries & Galloway, Fife, Forth Valley, Glasgow & GC, Grampian, Highland, Lanarkshire and Lothian). The rankling scale is from 1st – 11th with 1st representing the best performance	TOPAS	TTG Validated data available on 5th of month for previous month's data. SOT & Diagnostics available on 18th of month for previous month's data.	August 2016
Unavail-ability	Measures the number of patients on the new outpatient or Inpatient/Daycase waiting list who have a clock start date that has been adjusted by period(s) of unavailability i.e. where the patient is deemed unavailable for treatment for medical of social reasons. The Scottish Average provided as a benchmark is based on the % of patients unavailable for 30th June 2014 for NHS Scotland (data source - ISD).	TOPAS	Validated data available on 18th of month for previous month's data.	August 2016
A&E	Measures the % of patients discharged / admitted / transferred within 4 hours of their arrival at A&E, excluding planned return and recall patients. Rankings are based on the same criteria as described above for TTG/SOT.	Symphony	Validated data is available on the 15th of each month for the previous month data.	August 2016
18 Week Referral to Treatment	Measures the % performance and % completeness for admitted, non admitted and combined (admitted & non admitted) pathways. *Performance* measures the % of patients seen within 18 weeks from referral to treatment. *Completeness* measures the % of patients with a linked pathway, the whole pathway can be measured from date of receipt of referral to treatment date. The Scottish Average provided as a benchmark is based on the performance across Scotland as published by ISD.	Aridhia UPT	Validated data is available on the 20th of each month for the previous month's data.	August 2016
Cancer Waiting Times	*31 Day Target* - Measures the time from the date of decision to treat until the date of first treatment for 9 major cancer groups. The information includes 31 day performance for all referrals. *62 Day Target* - Measures the time from the date of receipt of initial referral into secondary care until the date of first treatment for 9 major cancer groups. The information includes 62 day performance for all patients referred urgently with a suspicion of cancer and for screened positive patients. *Cancer Groups*: Colorectal, Breast, Haematology, Head & Neck, Lung, Skin, Upper GI, Urology, Gynaecology. Rankings are displayed to compare our performance with that of the 10 other territorial boards. This ranking is based upon performance across Scotland as published by ISD. # The board are advised that whilst cancer waiting times figures are validated on a monthly basis, a final quarterly validation is undertaken approximately one month following quarter end which can result in some minor variations to the reported position. Figures included are the final validated figures for quarter 1 2015/16.	eCase	The submission date is the 20th of the month. The validated report is signed off by AMD or GM (Access) on or around, the 19th of each month.	August 2016

NHS Tayside

ACCESS — Board Performance Update, as at end August 2016

Improved performance ↑	Same performance ↔	Worse performance ↓

Waiting Times

		Jun-16	Jul-16	**Aug-16**	Target	Variance from LDP	Ranking	Performance	On Track
Treatment Time Guarantee / Stage of Treatment	Inpatient/Daycase patients treated and waited more than the 84 days TTG target	373	257	**467**	0	N/A	9th	↓	X
	Inpatient/Daycase patients waiting > 84 days TTG target as at month end	835	949	**910**	0	+23	#8th	↑	X
	New Outpatients waiting > 12 weeks target as at month end	3318	4513	**5143**	0	+1288	#5th	↓	X
	% of New Outpatients waiting < 12 weeks as at month end	83.7%	79.1%	**76.3%**	95%	N/A	6th	↓	X
	Number of New Outpatients waiting > 16 weeks as at month end	1749	2331	**2981**	0	N/A	5th	↓	X
	Diagnostics–8 key tests waiting > 6 weeks target as at month end	191	145	**141**	0	-73	5th	↑	X

		Jun-16	Jul-16	**Aug-16**	Target	Scottish Ave	Performance	On Track
Unavailability	% total IP / DC unavailability	15.3%	12.2%	**13.6%**	-	16.7%	↓	✓
	of total % medical	3.2%	1.9%	**2.4%**	-	3.3%	↓	✓
	of total % patient advised	11.3%	9.8%	**10.8%**	-	9.6%	↓	X
	of total % of patient requested	0.8%	0.5%	**0.5%**	-	3.8%	↔	✓
	% total OP unavailability	1.09%	1.03%	**1.29%**	-	3.0%	↓	✓
	of total % medical	0.04%	0.04%	**0.05%**	-	0.2%	↓	✓
	of total % patient advised	0.99%	0.91%	**1.22%**	-	1.6%	↓	✓
	of total % of patient requested	0.06%	0.08%	**0.03%**	-	1.2%	↑	✓

		Jun-16	Jul-16	**Aug-16**	Target	Variance from LDP	Ranking	Performance	On Track
A&E	A&E patients seen within 4 hour target	99.0%	99.3%	**98.0%**	95%	0%	1st	↓	✓

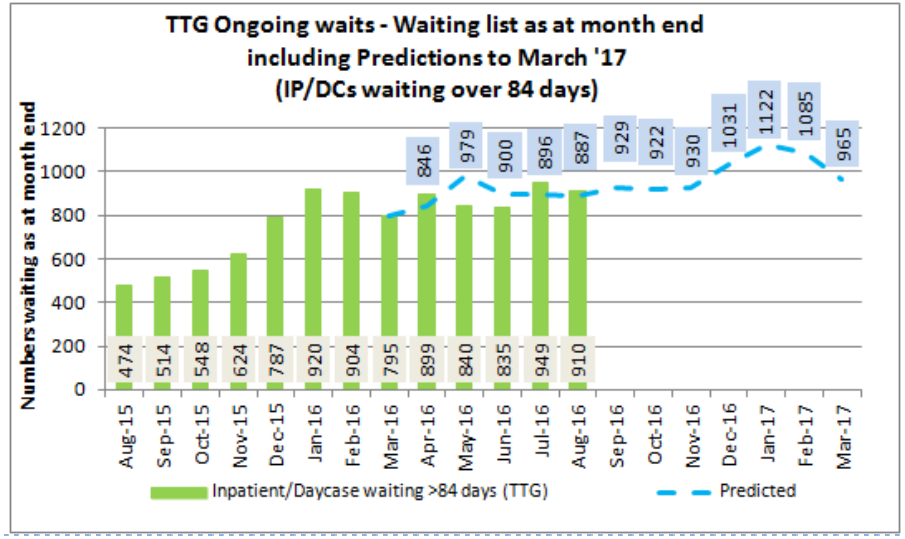
		Jun-16	Jul-16	**Aug-16**	Target	Ranking	Performance	On Track
18 wks RTT combined (including Audiology)	% of patients seen within 18 weeks – combined performance	88.8%	88.8%	**85.7%**	90%	6th	↓	X
	% of admitted patients seen within 18 weeks	60.7%	57.2%	**55.9%**	90%	6th	↓	X
	% of non admitted patients seen within 18 weeks	91.3%	91.3%	**88.5%**	90%	6th	↓	X
	% of patients linked to original referral combined completeness	99.5%	99.4%	**99.6%**	90%	3rd	↑	✓
	% of admitted patients linked to original referral	94.1%	92.7%	**95.2%**	90%	9th	↑	✓
	% of non admitted patients linked to original referral	100%	100%	**100%**	90%	1st =	↔	✓
	% of patients with 18 week RTT outcome codes completed	98.5%	98.6%	**98.4%**	90%	3rd	↓	✓

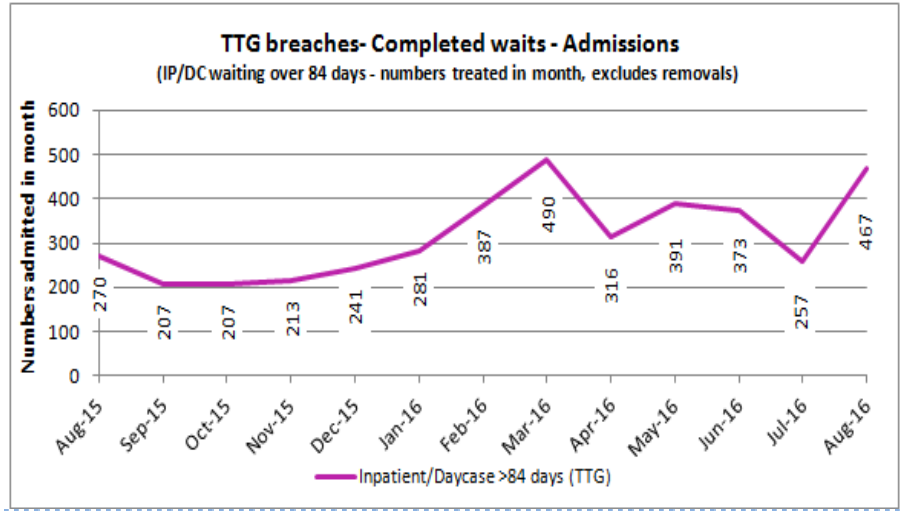
		Jun-16	Jul-16	**Aug-16**	Target	Ranking	Performance	On Track
Cancer Waiting Times	31-day target	96.6% *	91.4%	**88.8%**	95%	9th	↓	X
	62-day target	94.4% *	87.3%	**82.4%**	95%	7th	↓	X

**Due to updated submissions the June'16 positions have been amended for both 31 and 62 day Cancer WT attainment. #Rankings based on NHSScotland Weekly Service Pressures (Period Ending 02 October 2016)*

Rankings and Scottish average for Unavailability – Please note these apply to the June'16 position across Scotland, excluding Island Boards. National data is only released quarterly; the September 2016 position will be available late November 2016. Completed waits = Quarter end position. Unavailability came from INP/DC & OP qtly releases.

Inpatient/Daycase TTG – Ongoing Waits and Completed Waits





Ongoing waits

At the end of August 2016, **910** patients had been waiting over 12 weeks for admission compared to 949 at the end of July. The 910 patients are in the following specialities; **307** Orthopaedics; **203** General Surgery (ex Vascular); **192** Urology; **71** Plastic Surgery; **53** Ophthalmology; **30** Gynaecology (includes 19 patients for mesh procedures); **22** Cardiology; **18** Vascular Surgery; **5** ENT Surgery; **4** Paediatric Dentistry; **2** OMFS; **1** Neurosurgery; **1** Medical Paediatrics and **1** Paediatric Surgery.

Current performance in respect of ongoing waits (910 at the end of August) places us behind the trajectory (887).

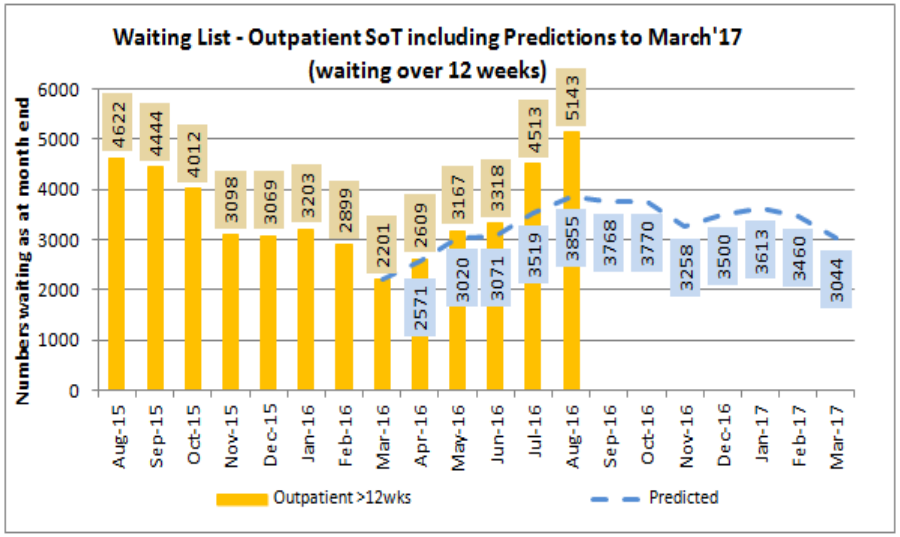
Completed waits

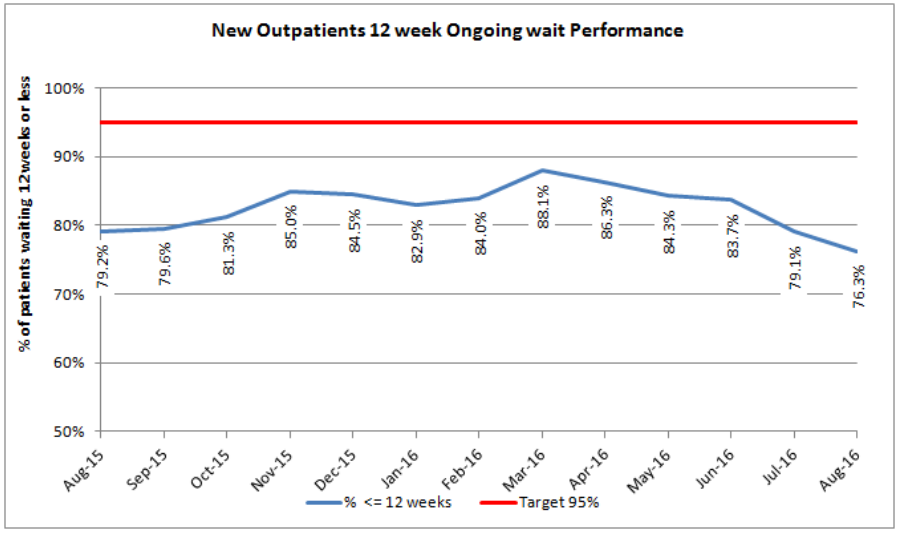
In August 2016 the number of TTG breaches admitted increased to **467** from 257 in July. Of the 467 breaches, **152** occurred within Orthopaedics, **87** Urology; **76** Ophthalmology; **62** General Surgery; **34** Plastic Surgery; **15** Cardiology; **13** Gynaecology; **11** ENT Surgery; **7** Vascular Surgery; **5** OMFS; **2** Paediatric Dentistry **1** Neurosurgery; **1** Medical Paediatrics and **1** Surgical Paediatrics.

Current performance in respect of ongoing waits (910 at the end of August) places us behind trajectory (887) by 23 cases. Whilst Orthopaedics and General Surgery have the greatest volume of patients waiting over 84 days and continue to remain a challenge, these specialities are currently within their performance trajectories for the year with implementation of recovery actions having the impact anticipated.

The main variance from plans is for Ophthalmology (variance of 47 cases from plan). The services capacity was impacted due to a need to relocate some Intravitreal (IVT) injections from delivery within procedure rooms to theatre. This displaced theatre time that would have been used for Cataract procedures and resulted in an increased waiting time. Performance has started to stabilise and it is anticipated that the October position will start to demonstrate improvements.

New Outpatients waiting over 12 weeks target as at month end





12 week breaches (inc unavailable patients)

The position at the end of August 2016 shows an increase on July of 630 patients with **5,143 (142 unavailable), July 4,513 (63 unavailable).** The five specialities with the greatest number of patients waiting over 12 weeks were Dermatology 982, Gastroenterology 621, Gynaecology 564, Neurology 390 and General Surgery 324.

Current performance in respect of ongoing waits over 12 weeks (5,143 at the end of August) places performance adrift of trajectory by 1,288. The specialities that are currently most greatly contributing to this deviation from our forecast position are:

Dermatology, 538 more than planned. The speciality experienced an increase in referral rate greater than the usual seasonal trend resulting in increased waits. A new locum consultant commenced within the service in August however will be finishing in October, therefore action is being taken to secure a future appointment. Additional weekend clinic are to be run between October and December to support a reduction in the current queue.

Gastroenterology, 247 more than planned. A new consultant has commenced with the speciality in August and is supporting stabilisation of the current waits over 12 weeks. Plans to reduce the current queue are being developed for implementation through the remained of 2016/17.

Respiratory, 207 more than planned. The speciality commenced additional clinics in October that will run throughout the remainder of 2016-17 and will reduce the growth in waits over 12 weeks.

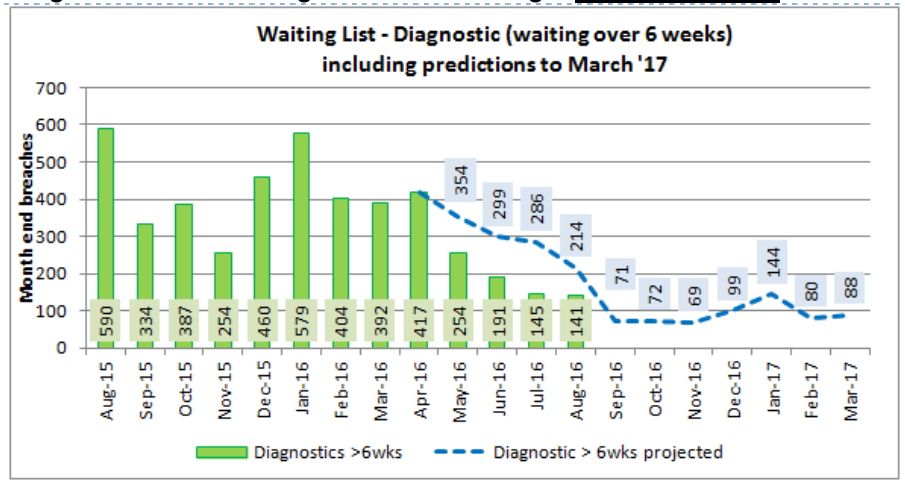
Neurology, 193 more than planned. The service plan for 2016-17 in order to meet required waiting times standards detailed the requirement to utilise the independent sector to support service delivery. A delay in securing dates for independent sector support in Quarter 1 has resulted in the deviation from trajectory however some activity has now been delivered and further dates have been secured for September which will support an improvement in performance.

As part of the Local Delivery Plan, NHS Tayside monitors on the percentage of patients waiting over 12 weeks for an outpatient appointment, with an expectation that performance will be no lower than 95%. At the end of August 2016 the performance was 76.3% which shows a continuing deterioration, the end of July 2016 position being 79.1%.

16 week breaches (inc unavailable patients)

From 1st April 2015 the Scottish Government expects all boards to measure outpatients waiting over 16 weeks, with an expectation that no patients will wait over 16 weeks for a new outpatient appointment. The total number waiting over 16 weeks at the end of August 2016 was **2,981** an increase of 650 compared to the end of July 2016 (2,331). This represents 86.3% of patients at the end of August 2016 having waited for 16 weeks or less to be seen and shows a decline on the July 2016 position (89.2%).

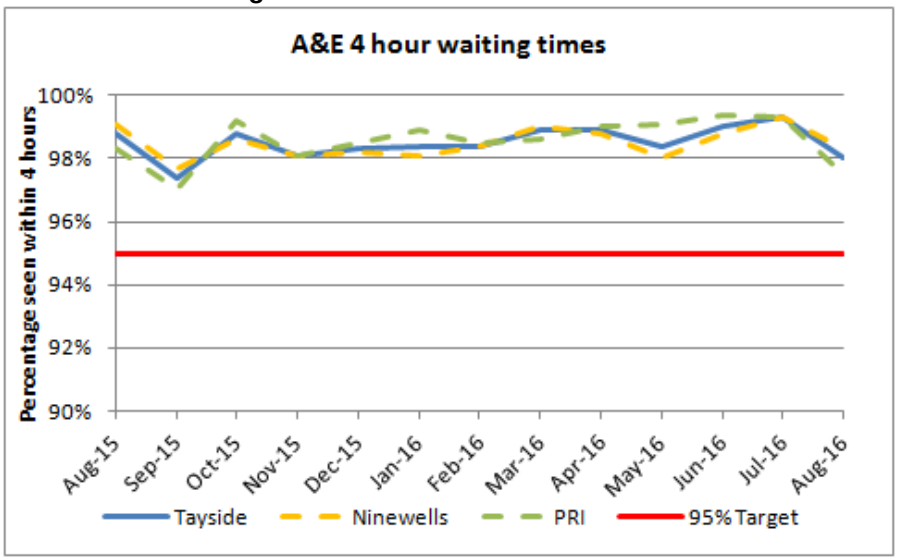
Diagnostic tests waiting over 6 weeks target as at month end



The number waiting over 6 weeks for Diagnostic Tests at the end of **August 2016** was **141** comprising the following breaches: - **69** Colonoscopy; **40** Upper Endoscopy; **18** MRI; **10** lower endoscopy (other than colonoscopy) and **4** Cystoscopy.

The August 2016 position represents a reduction in breaches on the July 2016 position (145) with the majority of patients waiting being for Colonoscopy or Upper Endoscopy. Current performance is ahead of trajectory and waiting times recovery plans for Colonoscopy, CT and MRI continue to progress effectively. Upper endoscopy is behind trajectory (actual 40, trajectory 10) due to a period of planned long term leave at Perth Royal Infirmary the effect of which is being monitored. It is anticipated that performance in September 2016 will be behind trajectory

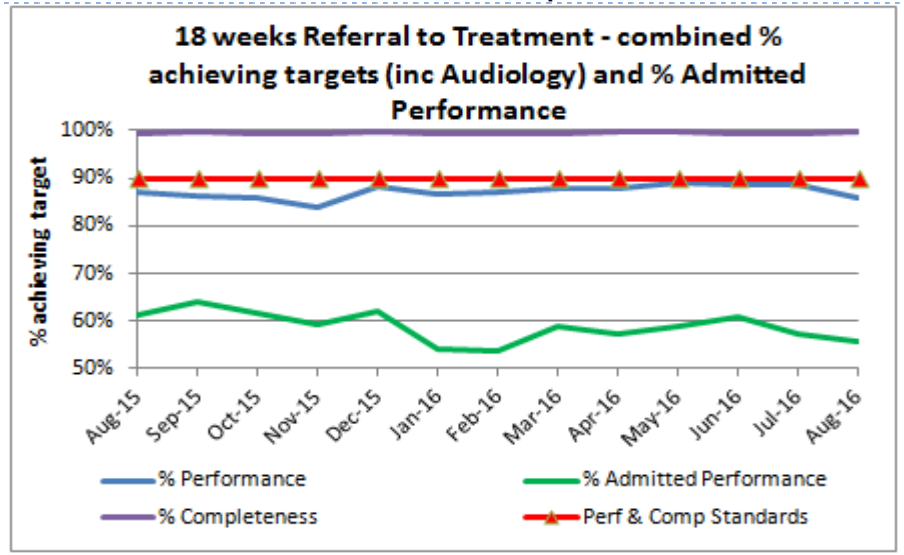
A&E 4 hour 95% target



Tayside continue to meet the 95% national target in August 2016. Ninewells reached the 98% Local Unscheduled Care Action Plan (LUCAP) target with an attainment of 98.3% whereas Perth Royal Infirmary achieved 97.5%. The overall attainment for Tayside was 98.0% in August 2016.

The action plan for 2016/17 is to continue to attain both the national 95% standard as well as the 98% local unscheduled care action plan target.

18 weeks Referral to Treatment Combined performance

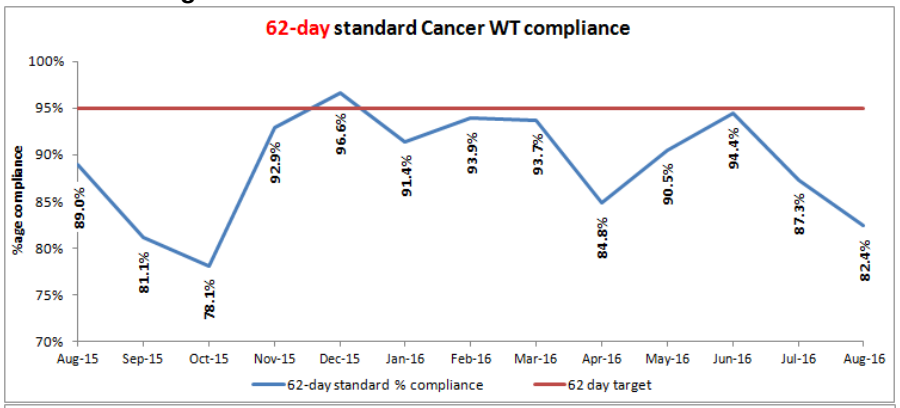


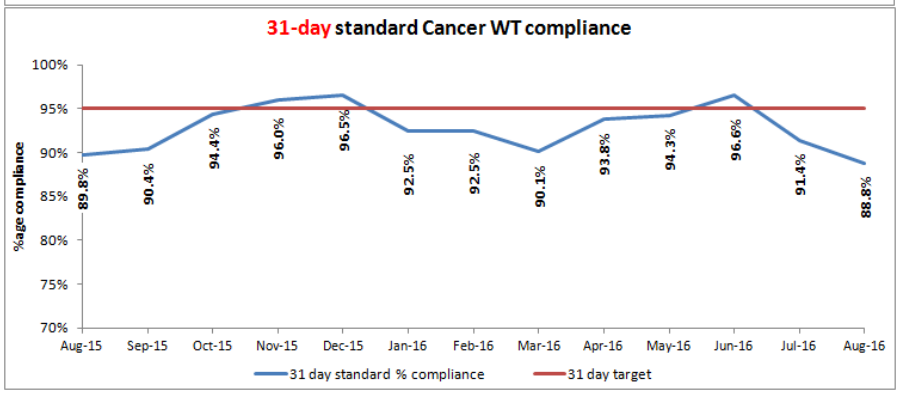
The 18 weeks referral to treatment combined performance continues to be below the 90% standard, and is impacted by the current waits for outpatients and TTG described above. The **August 2016** position decreased to **85.7%** compared to July 2016 (88.8%).

The main area of challenge is our admitted pathway, which declined further in August 2016 to 55.9% from 57.2% in July 2016. Gastroenterology, Dermatology, Community Dental Practice, Restorative Dentistry, Paediatric Dentistry, Haematology, Renal, Respiratory Medicine and Clinical Oncology achieved the admitted pathway standard in August 2016; however these are all specialities with low volumes requiring inpatient treatment. There were 13 specialities that did not achieve the admitted pathway standard in August 2016. These 13 include the specialities that currently have recovery plans in place for TTG.

The non-admitted pathway did not achieved the 90% standard in August 2016 with **88.5%** attained compared to 91.3% in July 2016. This is the 5th time the target has not been achieved in the twelve months to August 2016.

Cancer Waiting Times



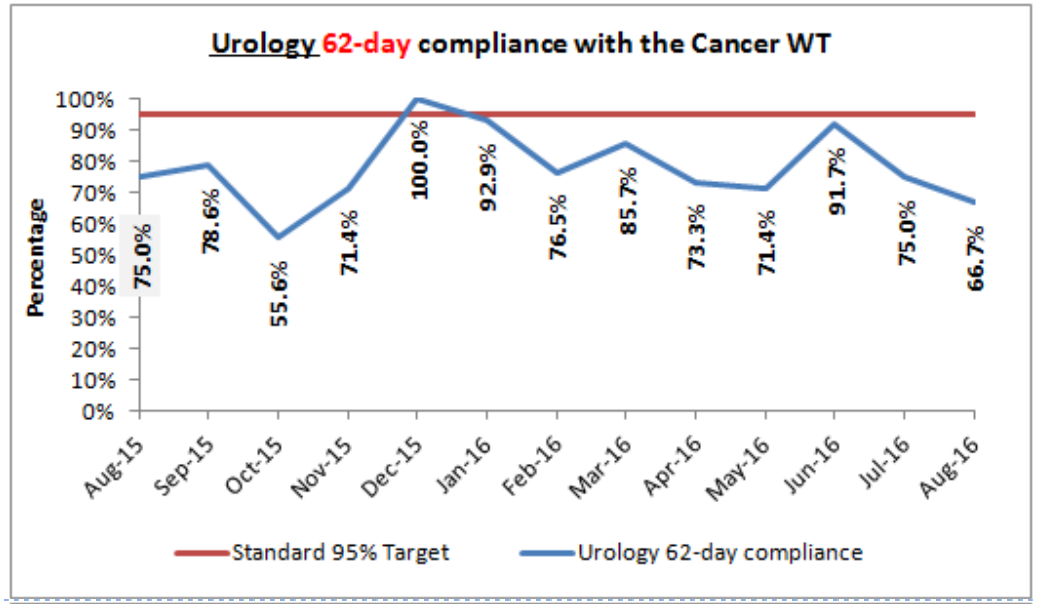


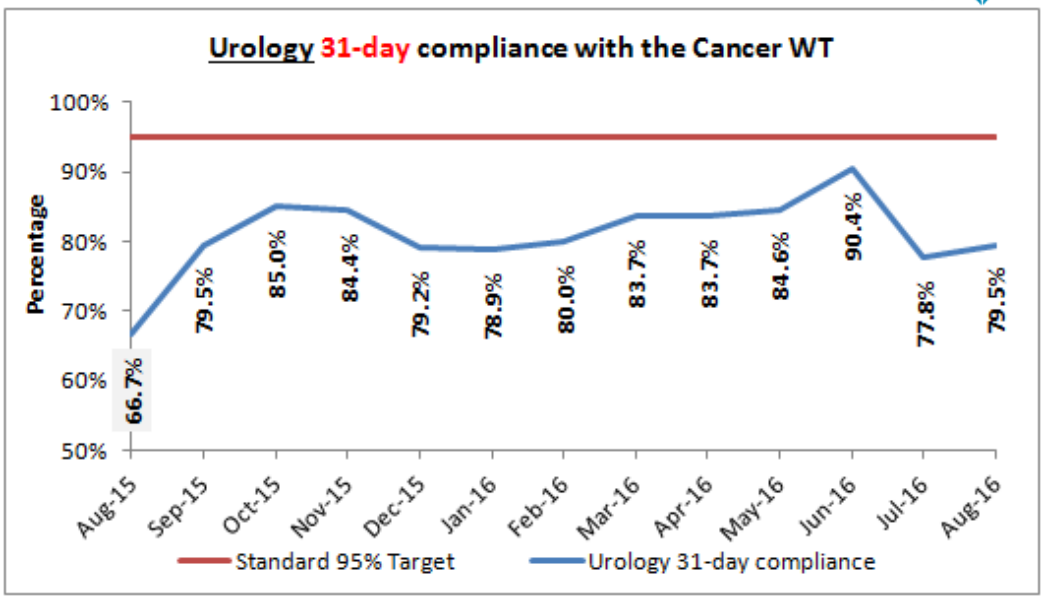
The **62 day** performance declined to 82.4% in August compared to 87.3% in July 2016. The sites not delivering the 62 day standard in August 2016 were Breast (5 breaches); Urology (5); Colorectal (1); Head and Neck (1) and Lung (1).

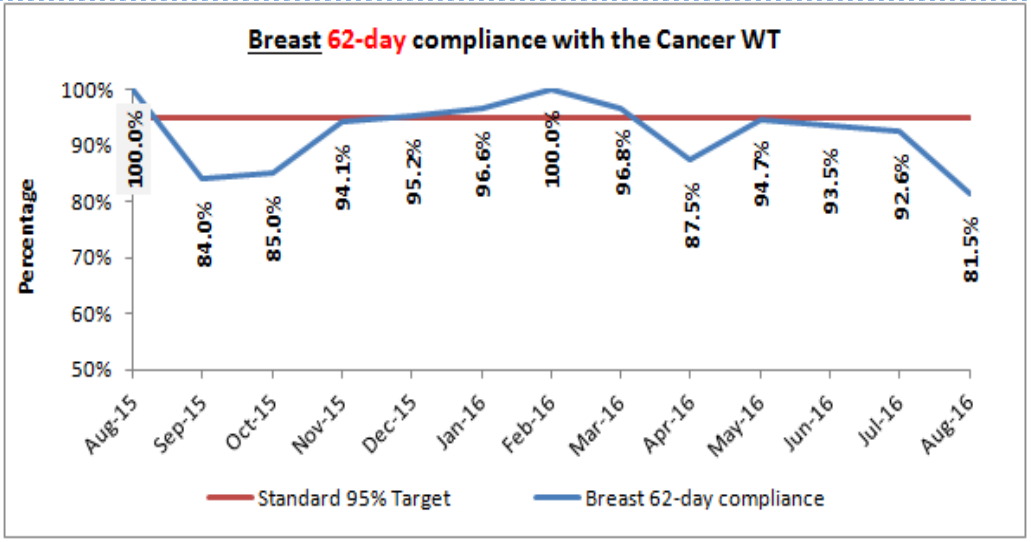
The **31 day** standard was not achieved in August 2016 with 88.8% a decline on July 2016 (91.4%). The sites not delivering the 31 day standard in August 2106 were Urology (9 breaches); Breast (9) and Head and Neck (1). There was also 1 breach in Lung but the 95% standard was met.

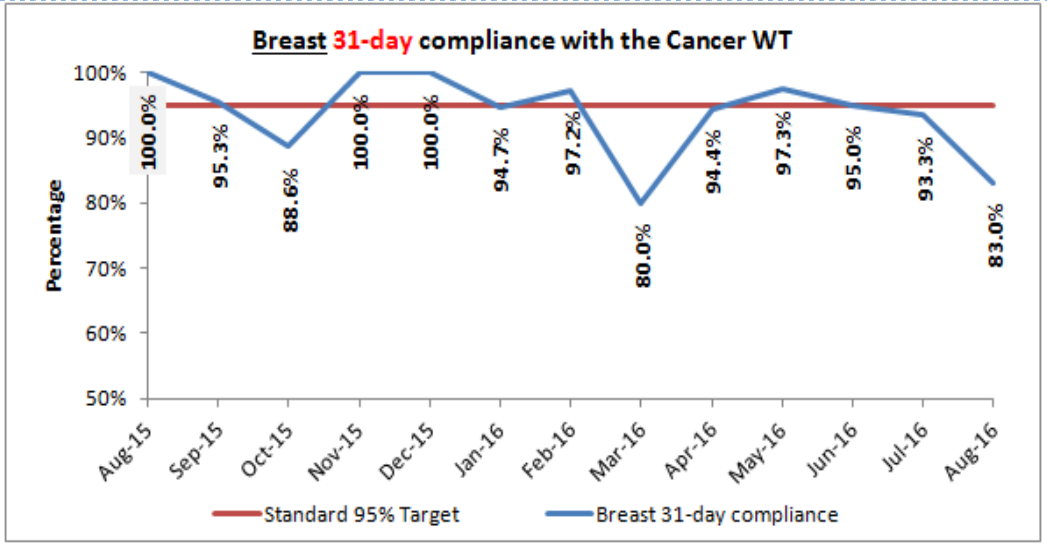
As previously reported to the Board the Urology service has two consultant vacancies and a single-handed surgeon for delivery of Laparoscopic Prostatectomy. The service is therefore relying on the support of two Locum Consultants and sessions from a retired Consultant to support service delivery. Discussions have taken place with Boards across Scotland to identify if any alternative capacity is available; however this has not been successful. In addition, robotic surgery is now being utilised in a number of sites and planning is taking place with NHS Grampian to secure both training and treatment sessions for NHS Tayside to commence utilisation of the robot. Fortnightly calls continue with Scottish Government to discuss our cancer waiting times performance and any associated risks and they are therefore well appraised of the continued workforce challenges within this speciality.

The Breast pathway was impacted by surgeon sickness absence coupled with an increase in demand. The service have returned to surgeon complement and are anticipating performance to improve towards December 2016. ? SNB


Urology 62-day compliance with the Cancer WT
Percentage
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
75.0%
78.6%
55.6%
71.4%
100.0%
92.9%
76.5%
85.7%
73.3%
71.4%
91.7%
75.0%
66.7%
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Standard 95% Target
Urology 62-day compliance


Urology 31-day compliance with the Cancer WT
Percentage
100%
90%
80%
70%
60%
50%
66.7%
79.5%
85.0%
84.4%
79.2%
78.9%
80.0%
83.7%
83.7%
84.6%
90.4%
77.8%
79.5%
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Standard 95% Target
Urology 31-day compliance


Breast 62-day compliance with the Cancer WT
Percentage
100%
90%
80%
70%
60%
50%
100.0%
84.0%
85.0%
94.1%
95.2%
96.6%
100.0%
96.8%
87.5%
94.7%
93.5%
92.6%
81.5%
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Standard 95% Target
Breast 62-day compliance


Breast 31-day compliance with the Cancer WT
Percentage
100%
90%
80%
70%
60%
50%
100.0%
95.3%
88.6%
100.0%
100.0%
94.7%
97.2%
80.0%
94.4%
97.3%
95.0%
93.3%
83.0%
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Standard 95% Target
Breast 31-day compliance

Waiting Times (continued)

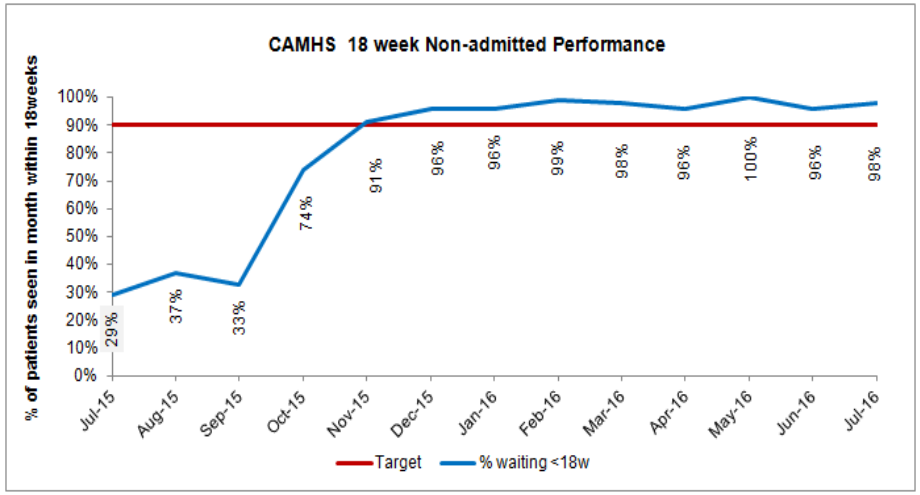
Measure	Definition	Data Source	Data Validation	Time Period Reported
Mental Health	*Child and Adolescent Mental Health:* Measures the % of patients treated in the month within 18 weeks from referral to treatment. The HEAT target set by Scottish Government was to achieve 90% compliance with 18 week RTT by the end of December 2014. *Psychological Therapies:* Measures the % of patients treated in the month within 18 weeks from referral to treatment.	TOPAS	Validated data is available on the 15th of each month for the previous month data.	August 2016
	Drug & Alcohol Services: Measures the % of clients treated within 3 weeks of referral.	Drug & Alcohol Database	Validated data is available on a quarterly basis.	June 2016
IVF Treatment	Measures the number of eligible patients commencing IVF treatment within 12 months. The clock start is the date that tertiary care agree the patient should have treatment. The clock stop is the date of the screening appointment. This is an emerging target set by Scottish Government to be achieved by March 2016.	TOPAS	Validated data is available on the 20th of each month for the previous month data.	August 2016

Improved performance ↑	Same performance ↔	Worse performance ↓

		Jun-16	*Jul-16*	***Aug-16***	*Target*	*Ranking*	*Performance*	*On Track*
Mental Health	CAMHS patients treated within 18 weeks from referral to treatment	100%	96.5%	**97.5%**	90%	1st	↑	✓
	Psychological Therapy patients treated within 18 weeks from referral to treatment	92.8%	93.3%	**93.3%**	90%	4th	↔	✓
		Apr-16	*May-16*	***Jun-16***	*Target*			
	Drug and Alcohol clients treated within 3 weeks from referral to treatment	97%	99%	**95%**	90%	5th	↓	✓
		Jun-16	*Jul-16*	***Aug-16***	*Target*		*Performance*	*On Track*
IVF	% of patients seen within 12 months from agreement to treat to screening	100%	100%	**100%**	100%	1st =	↔	✓

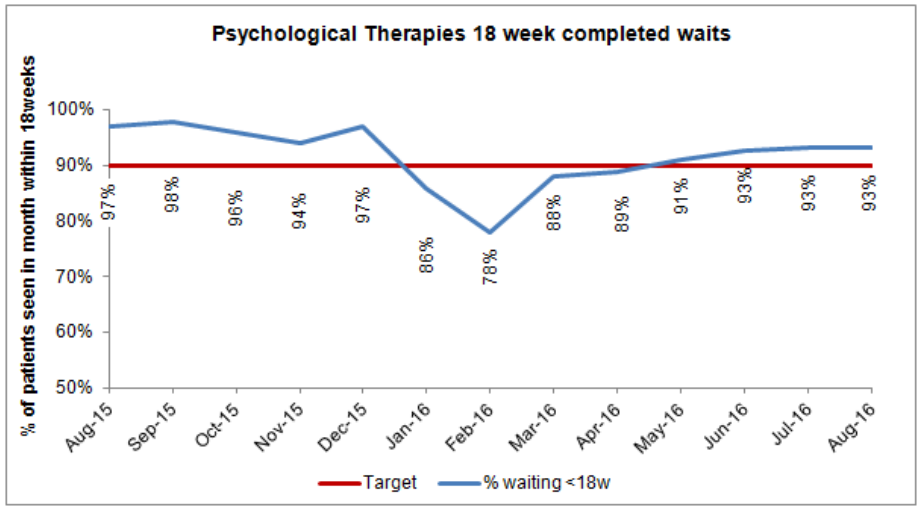
Rankings – Please note these apply to the June'16 position across Scotland, excluding Island Boards. National data is only released quarterly; the September 2016 position will be available late November 2016. Completed waits = Quarter end position.

CAMHS



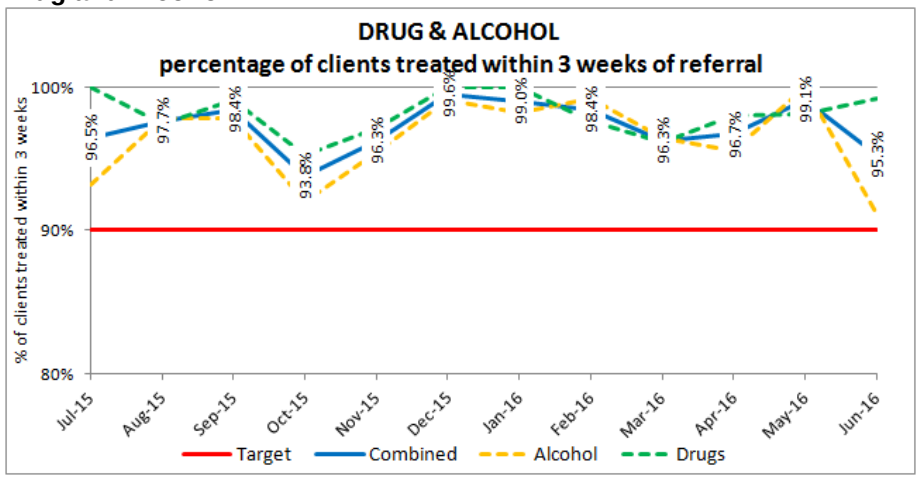
The 18 week Performance target was met in August 2016 with 97.5% being attained. The target has been met since December 2015.

Psychological Therapies



The Psychological Therapy 18 week referral to treatment performance was achieved in August 2016 with 93.3%. This shows a sustained position on July 2016, also 93.3%.

Drug and Alcohol



The HEAT standard is monitored on quarterly performance. This was 97.0% for the quarter to June 2016 (a slight decline on the previous quarter, 97.8%) however the standard was achieved. It should be noted that in June there was a decline in performance for the alcohol pathway. This decline in performance occurred within Dundee alcohol services. The main challenge in sustaining performance within the service is staffing levels to meet the demand for assessment and treatment, including detox/relapse prevention programmes, across both the alcohol and drug pathways. The service are commencing work to consider the implementation of a direct access model for both drug and alcohol pathways and will also review staffing across the service as newly qualified practitioners commence in October 2016.

This measure is updated quarterly with the next update being available late Oct 2016.

IVF

Since the introduction of a standard for IVF, NHS Tayside have consistently achieved 100% of patients seen within 12 months from agreement to treat to screening, with waiting times typically 9 months.

In June 2016 it was announced by Scottish Government that a change in the eligibility would be introduced. This would see guidance that had prevented couples where one partner had a biological child from being eligible, change so couples in this situation would now be eligible for fertility treatment. This change was implemented on the 1st September 2016. Further changes to the number of cycles couples are eligible for (currently two) are also being debated with a recommendation from the National Infertility Group to introduce a maximum of three cycles. Due to NHS Tayside's current positive performance with waits under the 12 month standard, we intend to actively monitor the impact of the revised guidance over the next 6 months to determine if any further action is required to ensure the waiting time continues to be met.

Efficiency Definitions — Board Performance Update, as at end August 2016

Improved performance ↑	Same performance ↔	Worse performance ↓

Efficiency

Measure	Definition	Data Source	Data Validation	Time Period Reported
Same day surgery	Measures performance against BADS procedures as defined by the British Association of Day Surgeons. 'Day Surgery' includes Outpatient procedures, Day Cases and Inpatients with a length of stay of zero.	TOPAS	Validated data is available 6 weeks after the month end to allow for clinical coding to be completed.	July 2016
Pre-operative Patient stay	Measures the pre-operative stay for inpatients who are admitted for a planned procedure for **surgical specialties** only (number of days of elective pre-operative bed days / number of elective procedures for surgical specialties). Medical specialties and emergency activity excluded.	TOPAS		July 2016
Elective length of stay Acute service	Measures the average length of stay for planned admissions within acute specialties across the 3 main acute hospital locations (number of elective occupied bed days for acute specialties in 3 main acute hospital locations / number of elective episodes admitted in same period).	TOPAS	Validated data is available 6 weeks after the month end to allow for clinical coding to be completed.	July 2016
Emergency length of stay Acute service	Measures the average length of stay for emergency admissions within acute specialties across the 3 main acute hospital locations (number of emergency occupied bed days for acute specialties in 3 main acute locations / number of emergency episodes admitted in same period).	TOPAS		July 2016
Delayed Discharges	Measures the total number of patients delayed at the census date (15th of every month). The measure excludes patients with a complex reason for delay and patients awaiting commissioning / reprovisioning of services. Complex reasons are, for example, patients awaiting placement in a high level needs specialist facility or where adults lack capacity under adults with incapacity legislation etc.	EDISON	Validated data is provided as at 15th of every month and submitted by 25th of every month.	August 2016
Readmission rates	Measures the number of patients re-admitted as an emergency within 7 and 28 days of their discharge as a rate per 1000 admissions. There are separate measures for Surgical and Medical re-admissions and the information is standardised by age, sex and deprivation (SIMD 2009). The data presented is produced by the Information Services Division (ISD) and shows NHS Tayside's performance compared to the rest of Scotland	ISD, Hospital Scorecard	Data submitted to ISD is validated through clinical coding.	Quarter 4 2015/16 (Jan 16 – Mar 16)
Outpatient activity	*New: Return ratio (1:)* Measures the return attendances in proportion to new attendances for all acute consultant-led activity. *Did Not Attend Rate* Measures the number of patients who do not attend for their acute consultant-led outpatient consultation.	TOPAS/ Qlikview	Validated data is available 6 weeks after the month end to allow for clinical coding to be completed.	July 2016

EFFICIENCY TARGETS — Board Performance Update, as at end August 2016

Improved performance ↑	Same performance ↔	Worse performance ↓

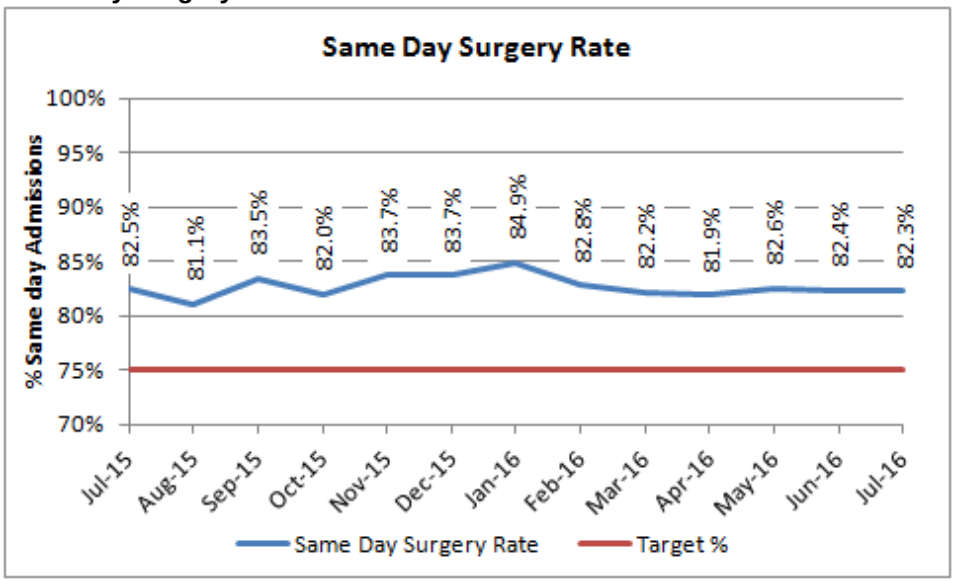
Same Day Surgery	May-16	Jun-16	**Jul-16**	Target	Performance	On Track
Same Day Surgery Rate	82.6%	82.4%	**82.3%**	75%	↓	✓
Pre-operative Patient Stays	0.25	0.25	**0.26**	0.71	↓	✓

Patient Flow	May-16	Jun-16	**Jul-16**	Target	Performance	On Track
Elective Average Length of Stay in Days – Acute Services	**3.0**	3.0	**2.8**	-	↑	n/a
Emergency Average Length of Stay in Days – Acute Services	**3.8**	4.0	**3.8**	-	↑	n/a
	Jun-16	Jul-16	**Aug-16**	Target	Performance	On Track
Delayed Discharges as at census date (15th of the month)	48	51	**62**	0	↓	x
	Qtr 2 2015-16	Qtr 3 2015-16	**Qtr 4 2015-16**	Benchmark	Performance	On Track
Re-admission Rate - Tayside **Medicine 7 day**	52.7	52.9	**61.3**	55.1	↓	x
Re-admission Rate - Tayside **Surgery 7 day**	23.9	25.0	**20.7**	22.9	↑	✓
Re-admission Rate - Tayside **Medicine 28 day**	131.8	124.3	**135.8**	115.7	↓	x
Re-admission Rate - Tayside **Surgery 28 day**	49.0	46.0	**43.8**	42.5	↑	x

Outpatient Activity	May-16	Jun-16	**Jul-16**	Target	Performance	On Track
Outpatient Acute Services - New : Review Ratio	2.1	2.2	**2.1**	-	↑	n/a
New Outpatient Acute Services Did Not Attend Rate	8.8% #	8.6%	**9.2%**	-	↓	n/a

Figure amended since previous report due to updated outcome codes

Same day Surgery rate



Same day surgery remains above target, achieving 82.3% in July 2016. All 3 acute sites have achieved the 75% target for the last 12 months, however we are aware from national benchmarking data that our performance varies from that of our peers and over the most recent 3 month period (May - July 2016), our performance ranked 10th when compared with the performance of all mainland boards and Golden Jubilee National Hospital (12 boards).

The implementation of Theatre Admission Suites (TAS) at Ninewells and Perth Royal Infirmary took place in July/August 2016 and it will be possible to assess the impact of this service development over future month.

Delayed Discharges

Looking at the numbers, a split of the delays by local authority has been provided as well as an indication of the total number of bed days lost as a result of patient delays both within an Acute and Community Inpatient setting. This information continues to demonstrate that the highest volume of delays is experienced in Perth & Kinross (24 as at August 2016 census point) although in August 2016 Dundee City also had high volumes (23 as at census point). From 1 April 2015, the national target is that no patients are delayed longer than 14 days (see further details on page 17).

In January 2015, the Cabinet Secretary for Health and Well-being announced additional new funding to tackle delayed discharges amounting to £100M spread over three years with the first tranche of £30m available from 1 April 2015. The Tayside partnerships' share of this first year funding will be £2.4m to support the work. Plans are progressing to invest in sustainable solutions that will seek to reduce unscheduled care and demand pressures as well as immediate discharge. The intention will be to move towards normalisation of discharge and working towards a standard of all patients being discharged back home (or equivalent) when medically fit and within 72 hours. Each Partnership has been asked to provide a Delayed Discharge Action Plan that identifies the priorities for action, the associated investment strategy and the trajectory for prospective improvement in the numbers of patients delayed and the lengths of delays. The Scottish Government are now moving from quarterly to monthly publication of the national delayed discharge performance data which will further challenge partnerships to demonstrate improvement underpinned by the investment.

The position for the 14 day target shows a decline in both July and August 2016. The 72 hour ambition showed an improvement in July but a further decline in August 2016. There continues to be significant numbers of patients delayed within our hospitals presenting a continued loss of productivity and capacity and flow. Above all, this can result in poorer outcomes for those patients delayed and impacts on the overall quality of care provided. A Tayside wide Winter Planning Performance Group has been established to oversee and monitor the delivery and performance of the winter plan including delayed discharges. Fast track escalation is also agreed to mitigate any emerging risks.

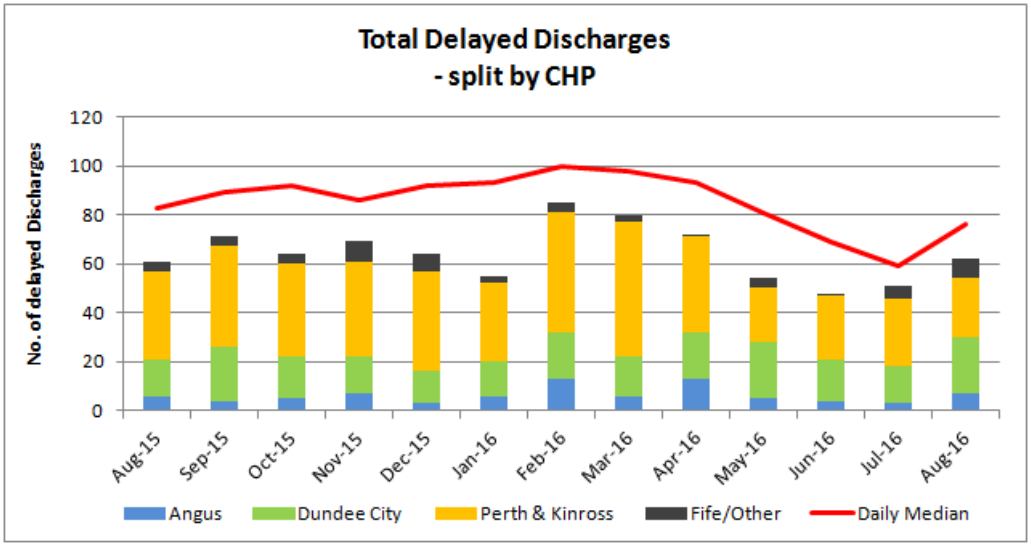
A significant programme of work has been initiated in Perth and Kinross (P&K) following the diagnostic visit by Brian Slater in January 2016. Comprehensive analysis of the patient pathway through acute care has demonstrated a number of factors impacting upon flow. Rather than considering the pressure of winter months alone, attention is now focused upon the whole system. A rapid improvement event revealed a number of areas for change and implementation of the recommendations is in progress. The combination of multi-disciplinary and multi agency daily safety huddles and board rounds on each ward have improved attention to the daily challenges of flow in clinical care. A weekly performance and resources meeting is held every Wednesday. This provides opportunity for each locality across Perth and Kinross to examine patients delayed in Perth Royal Infirmary (PRI), Murray Royal Hospital and community hospitals and those living in community awaiting home care, residential care and other forms of support in discharge. Approximately £1.7 million has been invested from Health and Social Care Partnership (HSCP) resources in supporting investment in residential care placements. Demand outstrips supply of home care (shortages of home care staff across private providers) Guardianship processes can cause significant delay but Perth and Kinross Council (PKC) has now introduced a scheme to accelerate the application process where private arrangements exceed 21 days. Further developments are planned including greater focus on assessment to admit and discharge to assess models. These initiatives will focus around a hub in PRI. Eventually, localities will undertake daily reviews for each patient in hospital or awaiting support in the community.

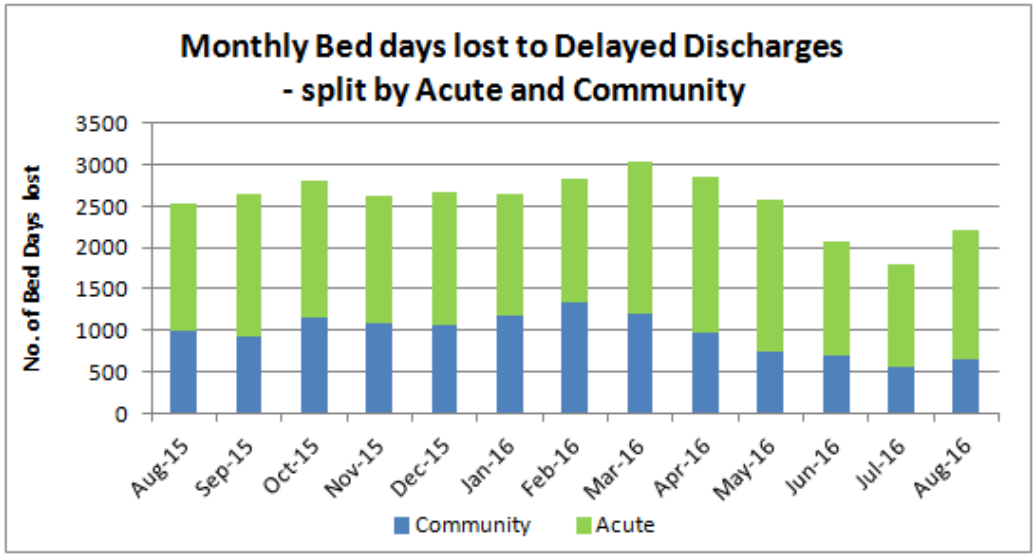
There is evidence in P&K of population need such that demand will continue to outstrip current resources and the HSCP team are working with the PRI General Manager to understand the trend data and communicate this back to NHS Tayside and PKC.

Dundee is making good progress in reducing time spent delayed in hospital for all patients where the standard maximum delay applies. This is reflective of a number of initiatives which have taken place within Dundee over the last two years. In particular, Care at Home, Occupational Therapy, Nursing Services and Mental Health Officer services have increased capacity to respond quickly to patients by streamlining of processes and provision of additional resource through discharge monies. In addition to this, Dundee has continued to increase availability of step down facilities through investment and upgrading of resources.

However, we recognise that there is further work required to enable Patients who have a complexity of circumstances to be discharged and Patients who require 24 hour care to be discharged when they are ready. At the same time, within Dundee, we recognise that these priorities must also be seen alongside reducing emergency admissions and readmissions to hospital and a focus on enabling people to live independently at home or a homely setting. Due to this an improvement plan has been established to continue our focus on making the strategic and operational shifts required to respond to these priorities and with that ensuring that Citizens of Dundee are supported at home, but when people do have to go to hospital they are only there as long as they need to be.

Delayed Discharges at Monthly Census point (excluding complex cases) and total bed days lost due to delayed discharges each month





The graph above demonstrates the number of patients delayed at census point by locality, and also shows the median number of patients who's discharge is delayed each day. This demonstrates that the daily median number of delays is greater than that experienced on our census date (15th of each month up to June 2016, last Thursday of each month from July 2016 onwards). The second graph demonstrates the total number of bed days lost to delayed discharges each month.

Number of delayed Discharge patients by Site (Source:- Edison)	Apr-16			May-16			Jun-16			Jul-16			Aug-16		
	Census date	Actual Median	Maximum	Census date	Actual Median	Maximum	Census date	Actual Median	Maximum	Census date	Actual Median	Maximum	Census date	Actual Median	Maximum
Perth Royal Infirmary	19	24	27	13	24	34	11	19	25	12	16	19	13	18	32
Royal Victoria Hospital	13	19	23	18	21	26	14	17	23	10	13	15	17	18	26
Ninewells Hospital	6	14	19	7	10	14	1	8	11	8	11	15	14	13	18
Crieff Community Hospital	4	5	8	3	4	6	5	7	9	6	4	6	4	4	7
Kingsway Care Centre	2	3	5	0	1	4	3	4	4	3	2	4	3	3	6
Murray Royal Hospital	8	7	10	4	11	13	4	3	5	3	4	5	2	3	6
Blairgowrie Community Hospital	5	6	8	0	1	2	1	2	2	2	1	3	0	2	3
Whitehills Health and Comunity Hospital	5	6	7	1	2	6	2	2	4	0	2	3	2	2	3
Pitlochry Community Hospital	3	4	6	1	1	3	3	2	3	0	1	2	1	1	2
Stracathro Hospital	3	3	5	1	2	4	1	2	5	1	1	2	2	2	4
St Margaret's Hospital	1	1	3	2	3	5	2	2	3	6	4	6	2	4	6
Bluebell Intermediate Care Centre	1	2	4	2	2	4	1	1	2	0	1	1	0	3	4
Montrose Royal Infirmary	1	2	4	1	1	2	0	1	2	0	0	1	2	0	2
Arbroath Infirmary	0	0	1	1	0	1	0	0	0	0	0	0	0	0	1
Strathmartine Hospital	0	4	4	0	0	0	0	0	0	0	0	0	0	0	0
Carseview Centre	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total (All locations)	72			54			48			51			62		

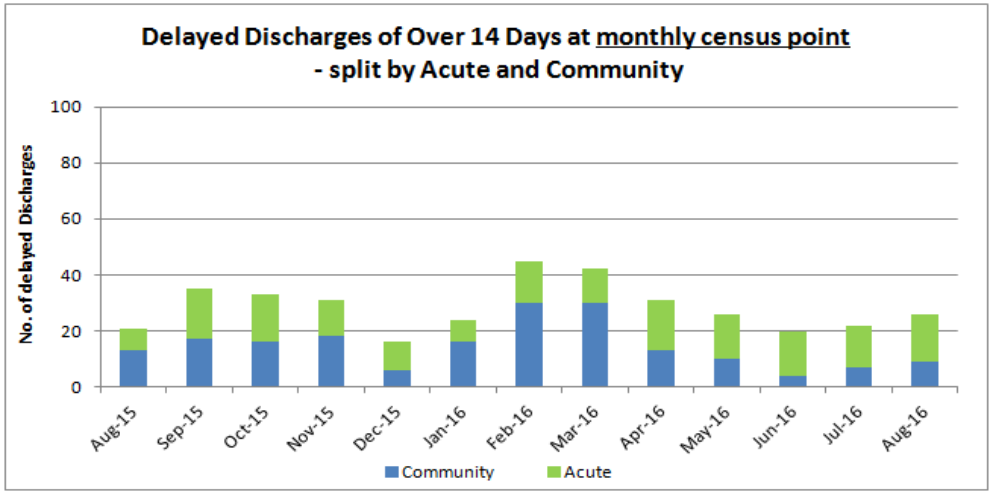
The table provides a breakdown by location of the patients delayed at census point for the 5 months to August 2016. In addition, the table shows the median daily number of patients delayed at each location in the month. This demonstrates that at census point the number of patients delayed is frequently lower than that experienced the rest of the month. In addition it can be noted the maximum number of patients delayed on one site on any one day in August 2016 was 32 patients in Perth Royal Infirmary.

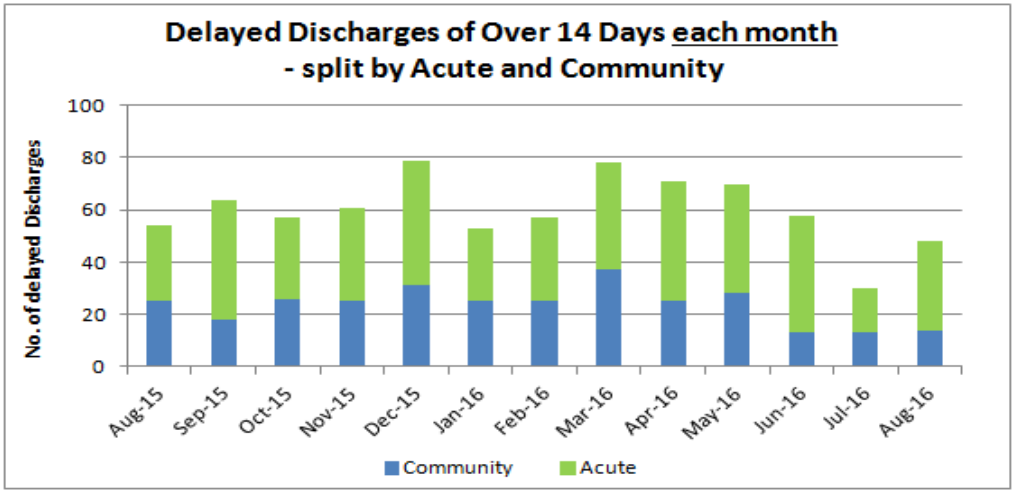
The measure excludes patients with a complex reason for delay and patients awaiting commissioning / reprovisioning of services.

Delayed Discharges

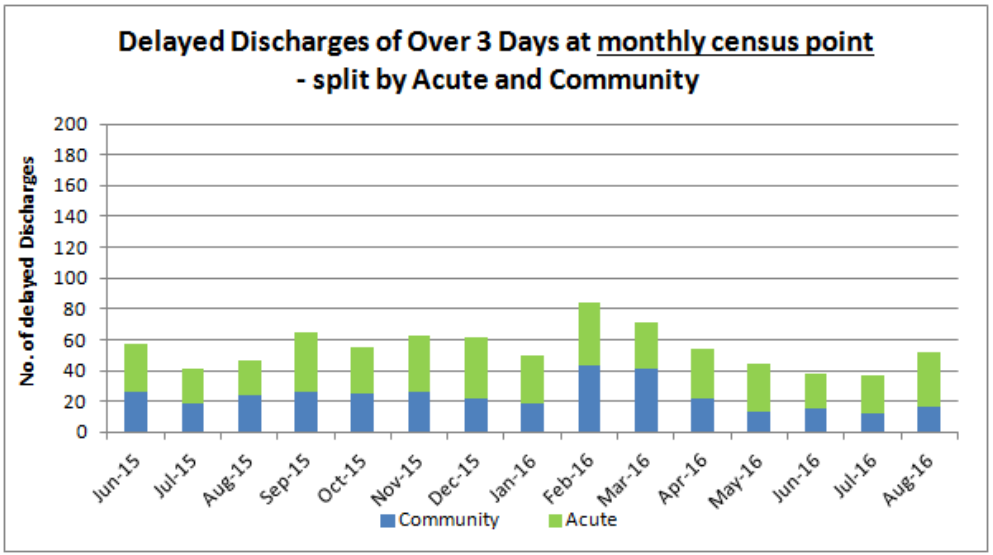
Scottish Government announced in October 2011, that from April 2015 no patient should wait more than 2 weeks from when they are clinically ready for discharge until they are discharged. This again is measured at the census date, and the first graph below shows the number of patients delayed at the census date who had been delayed for over 14 days. Whilst NHS Tayside is aware that national measurement is based upon a census date, we are keen to understand the position for all delayed patients, not just those delayed on the census date. The second graph below therefore shows the number of patients who were delayed for over 14 days at any time in the month. As stated above, the intention is to progressively move beyond this target towards a 72 hour discharge and to move from "assess to discharge" towards "discharge to assess" and to specifically seek to eliminate delays in acute settings.

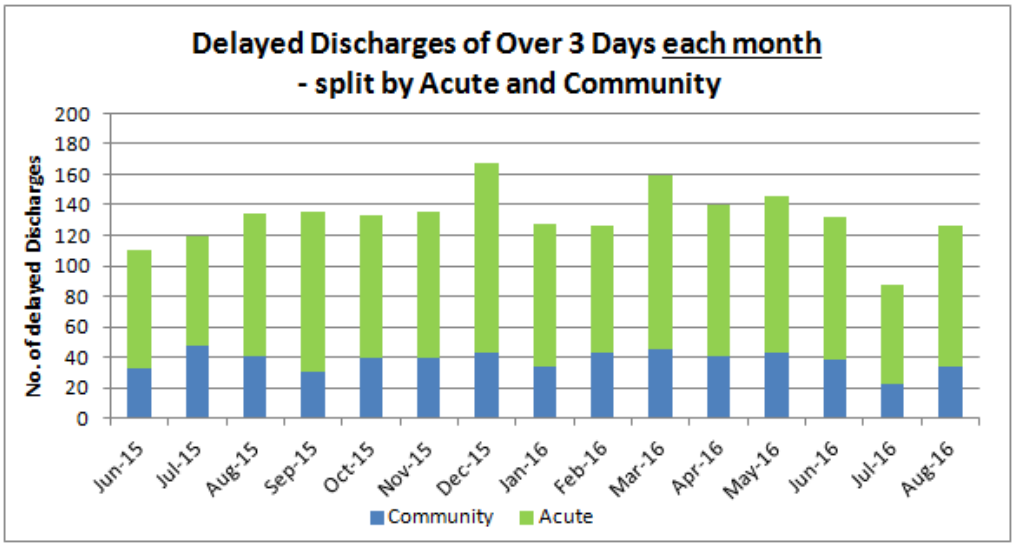
No non-complex cases will be delayed for greater than 14 days from April 2015





No non-complex cases will be delayed for greater than 3 days

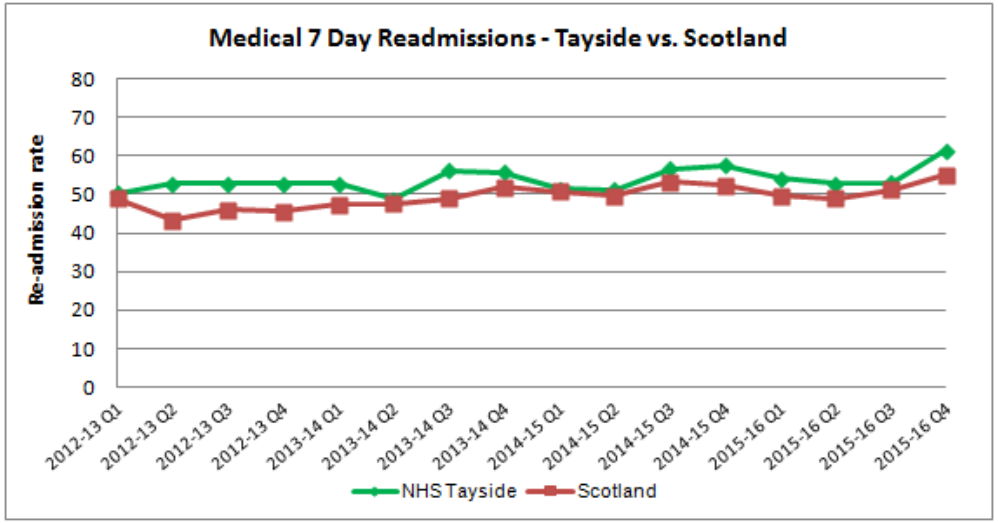


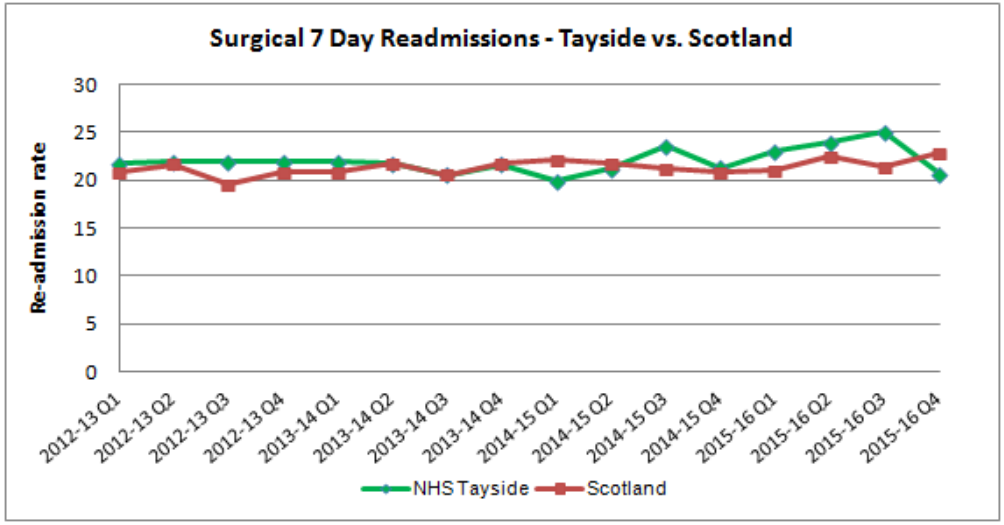


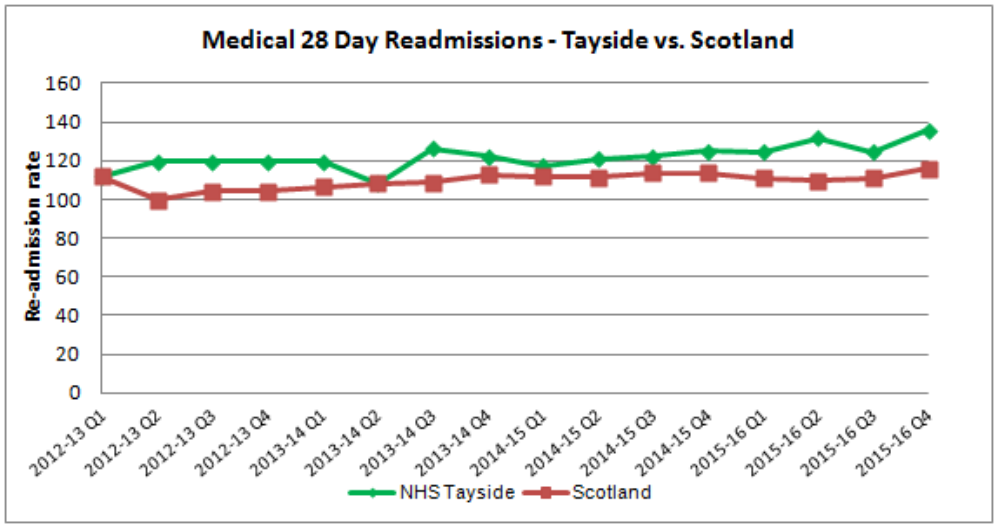
Readmissions

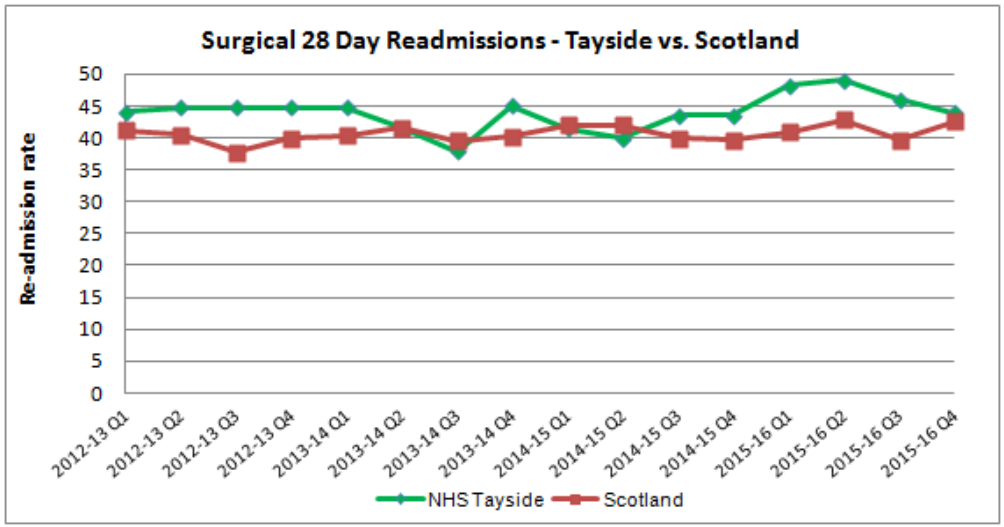
Every quarter Information Service Division (ISD) release a Hospital Scorecard which provides benchmark information in respect of key hospital based measures, including readmissions. This information enables comparison of our performance with that of other Boards and Hospitals. The latest information released by ISD covers the period 1st January – 31st March 2016 and shows, with the exception of the Surgical 7 day readmission rate, that NHS Tayside's Medical and Surgical Readmission Rates continue to be higher than the overall Scotland position. Provided below is a comparison of NHS Tayside's readmission rates compared to the overall Scotland position from quarter 1 2012-13. Dr Alan Cook has commissioned a clinical review of medical and surgical readmissions at Perth Royal Infirmary over the period October 2015 to March 2016 in order to identify any factors influencing our performance.

NHS Tayside Readmission Rates compared to the overall Scotland position *(Data source ISD Hospital Scorecard)*

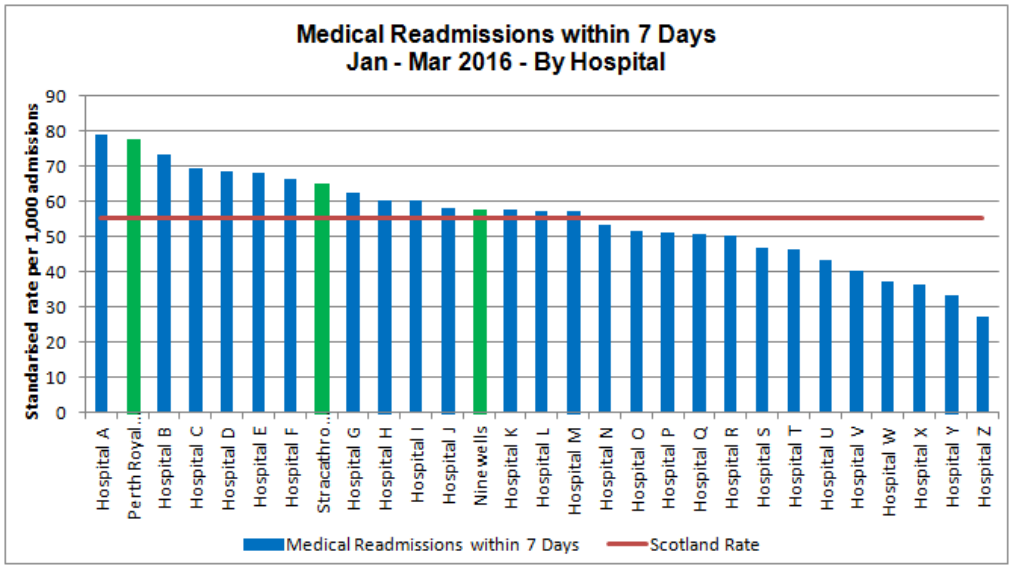


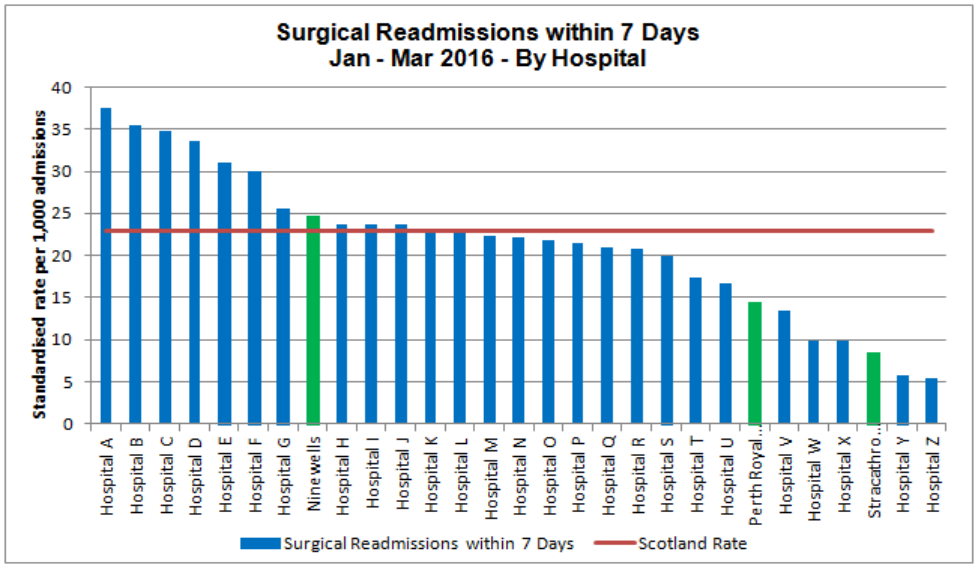


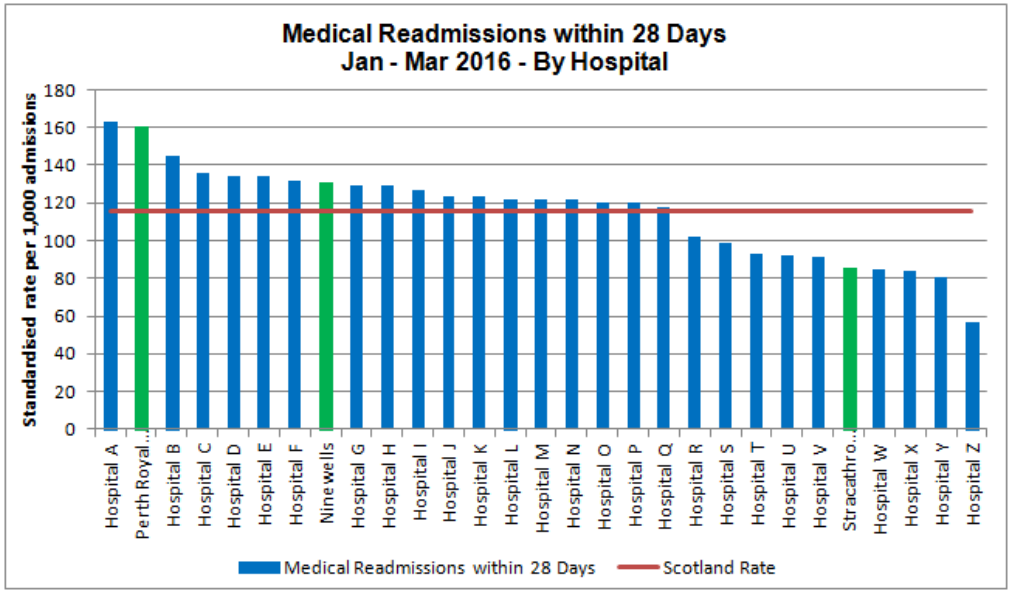


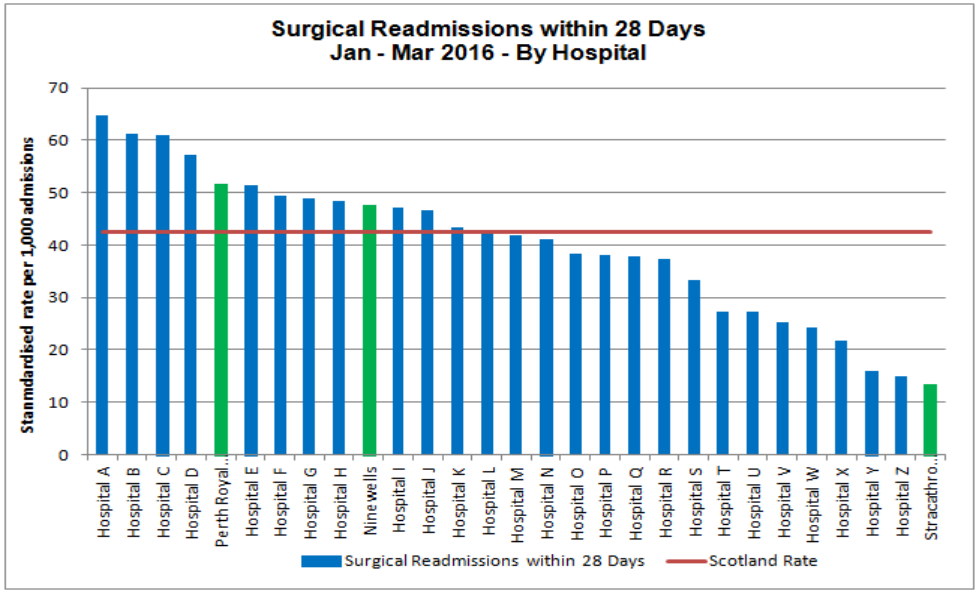


Hospital Level Readmission Rates – January - March 2016 *(Data source ISD Hospital Scorecard)*

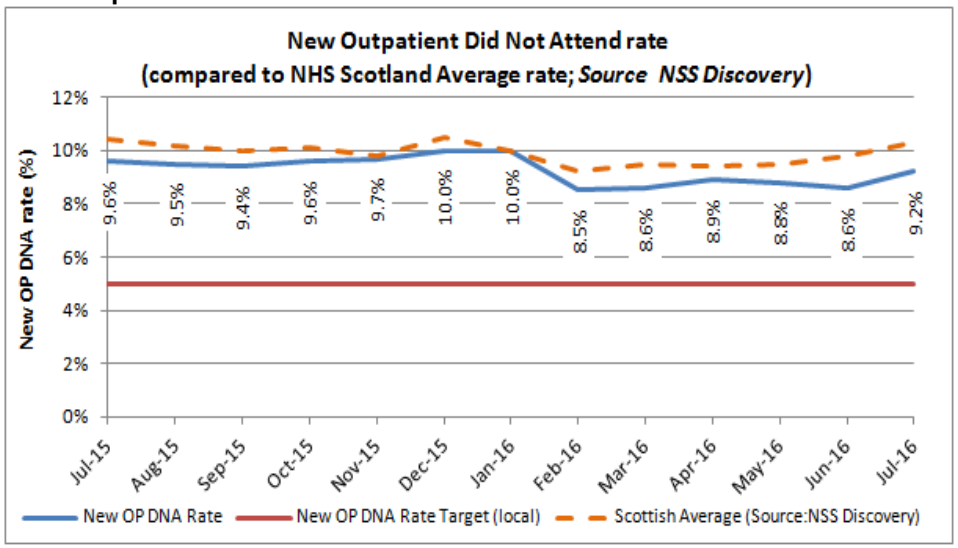








New Outpatient Did Not Attend rate



Whilst new outpatient DNA rates have been consistently higher than the 5% local target, it should be noted that NHS Tayside's DNA rate is below the Scottish Average

However, there remain opportunities for improvements and the Delivering Outpatient Integration Together Programme (DOIT) continues to support a number of programmes of work that support patient attendance. The focus of DOIT is on technology and workforce enabled models. NHS Tayside is in the progress of implementing a number of these models across a number of specialities.

The following Solutions (Systems) will be implemented over the next year.

1) Patient Reminder Services
2) Virtual Clinics
3) E- Advice Messages
4) Centralised Booking

Measure	Definition	Data Source	Data Validation	Time Period Reported
Mortality Rates	The HSMR value for Scotland for the baseline year is 1. This allows quarterly hospital values to be compared to the baseline year for Scotland. If an HSMR value is less than 1 this means the number of deaths within 30 days for a hospital is less than predicted. If an HSMR value is greater than 1 this means the number of deaths within 30 days for a hospital is more than predicted. However, if the number of deaths is more than predicted (HSMR is more than 1) this does not necessarily mean that these were avoidable deaths (i.e. that they should not have happened at all), or that they were unexpected, or attributable to failings in the quality of care.	ISD	This rate is calculated by ISD Scotland and published on a quarterly basis.	January – March 2016p
Clinical Quality Indicators	*Pressure Ulcer Incidents* Measures the number of pressure ulcers (grade 2, 3 and 4) that developed within NHS Tayside hospital settings (Perth Royal Infirmary, Aberfeldy Community Hospital, Pitlochry Community Hospital, Blairgowrie Community Hospital, St Margarets Community Hospital, Crieff Community Hospital, Ninewells, Royal Victoria Hospital, Arbroath Infirmary, Montrose Infirmary, Whitehills, Stracathro, Carseview, Murray Royal, Kingsway Care Centre and Strathmartine Hospital) that have been reported through Datix, by grade and if on investigation they were deemed avoidable or unavoidable. A rate per 1000 bed days for unavoidable pressure ulcers is also presented. *Fall Incidents/Patients* Measures the number of falls incidents reported through Datix. *Fall with Harm* Measures, of the falls incidents and patients affected reported, how many resulted in harm. *Nutritional Care* Measures the number of incidents reported within Datix of unintentional weight loss of either 5-10% of or greater than 10%.	Datix	Adverse Events are verified by a trained verifier and reviewed through clinical governance fora.	August 2016

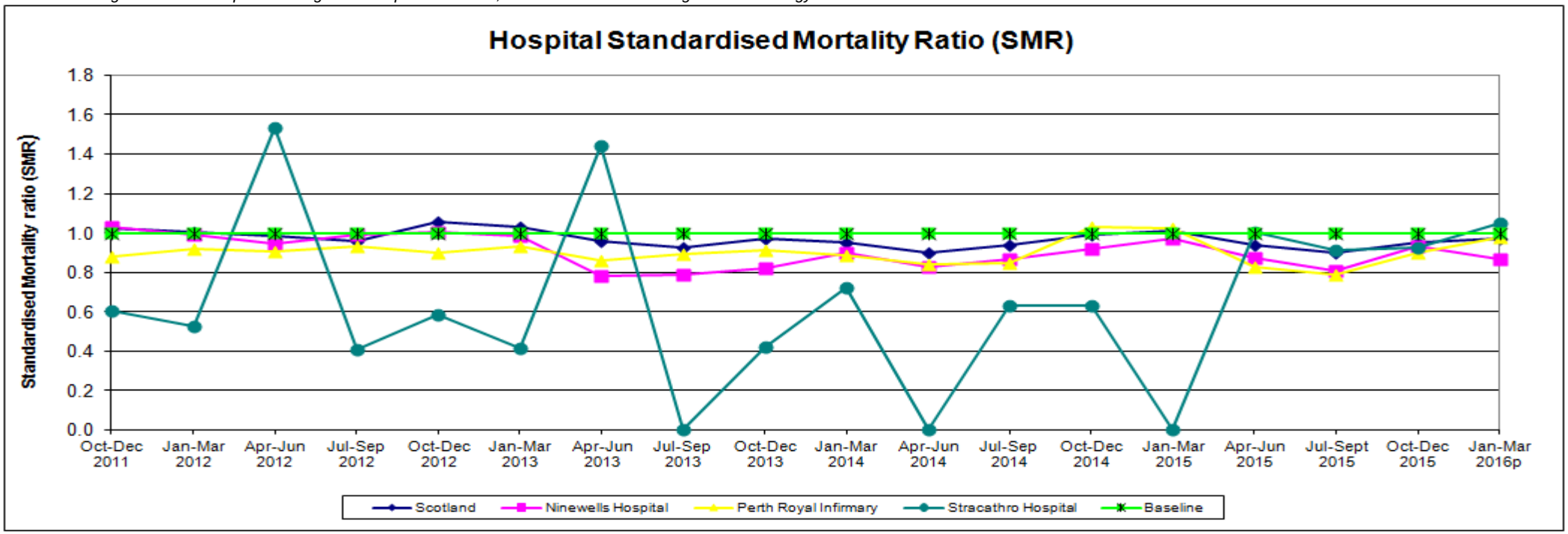
Hospital Standardised Mortality Rate

Improved performance ↑	Same performance ↔	Worse performance ↓

This rate is calculated by ISD Scotland and published on a quarterly basis

	Jul-Sept 2015	*Oct-Dec 2015*	***Jan-Mar 2016p***	*Baseline*	*Performance*	*On Track*
Ninewells Hospital	0.80 *	0.93 *	**0.87**	1.00	↑	✓
Perth Royal Infirmary	0.79 *	0.90 *	**0.98**	1.00	↓	✓
Stracathro Hospital	0.91 *	0.93 *	**1.05**	1.00	↓	x
Scotland Total	0.90 *	0.95 *	**0.97**	1.00	↓	✓

** Denotes change to ISD HSMR published figures from previous issue, see notes below on change in methodology.*



*** There are a number of factors which influence** HSMR values these include:

- Random variation: number of observed deaths particularly in smaller hospitals.
- Data quality: variations in completeness and accuracy of recording of data from patient records, particularly misattribution and coding of main diagnosis.
- Palliative care provision: the level of palliative care and terminal care support services in the community for the local population.

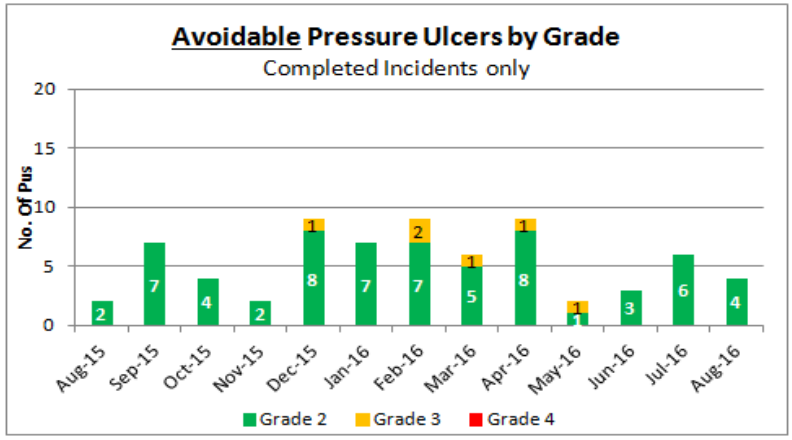
Analysis Mortality – The latest release of HSMR reports on progress towards the new aim to reduce hospital mortality by a further 10% by December 2018. This is measured from the end of a new baseline period – Jan'11 to Dec'13 to the latest quarter therefore all figure previously reported have changed due to this. It should also be noted that the methodology for calculating HSMR has been updated and as such the latest release is not comparable to any previous releases of HSMR data.
Ninewells is reporting an overall reduction (5.2%) in HSMR from the revised baseline whereas PRI (4.1%) and Stracathro (33.8%) are reporting an overall increase. Stracathro is a small hospital with very few observed deaths and as a result demonstrate wide variation in their mortality rate.

PATIENT SAFETY — Board Performance Update, as at end August 2016

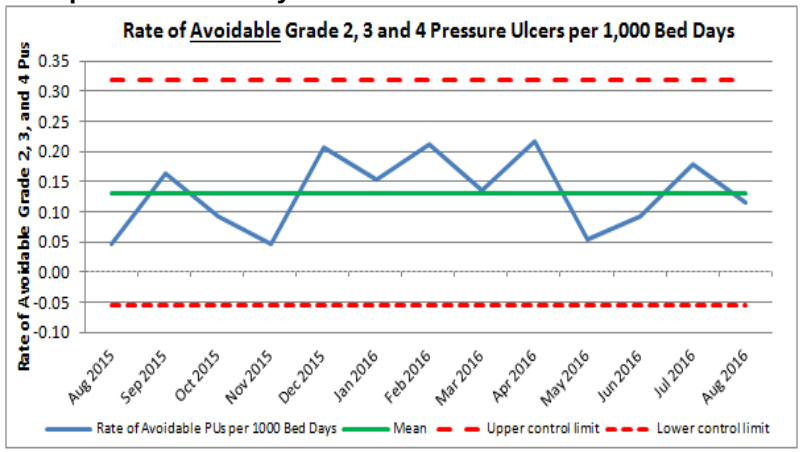
Increasing Numbers ↑	Same Numbers ↔	Decreasing Numbers ↓

Clinical Quality Indicators (all Directorates)		Jun-16	Jul-16	Aug-16	Trend	Target	On Track
Avoidable Pressure Ulcers	Numbers	3 *	6	4	↓		
	Rate per 1000 Bed Days	0.09 *	0.18	0.12	↓		
Unavoidable Pressure Ulcers	Numbers	13 *	11	4	↓		
	Rate per 1000 Bed Days	0.39 *	0.33	0.12	↓		
Patient Falls Incidents		281 *	237	229	↓	** revised figures as a result of incident verification and data input*	
Patient Falls with Harm		76	83	69	↓		
Nutritional Care – Incidents of Unintentional Weight Loss		1	0	4	↑		

Number of Avoidable Pressure Ulcers

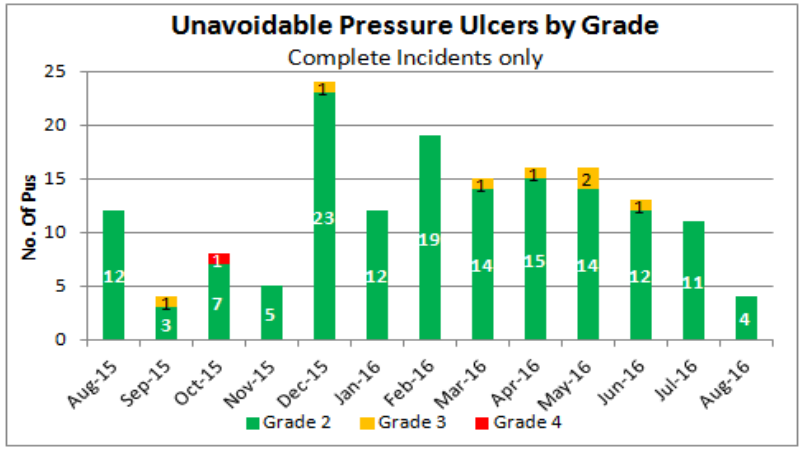


Rate per 1000 Bed Days of Avoidable Pressure Ulcers

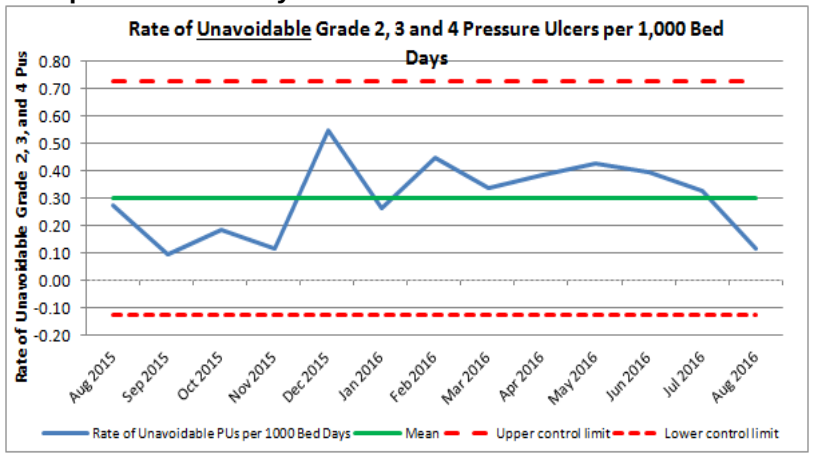


The information presented in respect of avoidable pressure ulcers demonstrates that in the 13 months to August 2016 there have been no grade 4 (serious) pressure ulcers deemed as avoidable, however 6 grade 3 (moderate) and 64 grade 2 (minor) pressure ulcers have been considered avoidable. The rate of avoidable pressure ulcers is consistently below 0.25 per 1000 bed days and remains within the upper and lower control limits.

Number of Unavoidable Pressure Ulcers



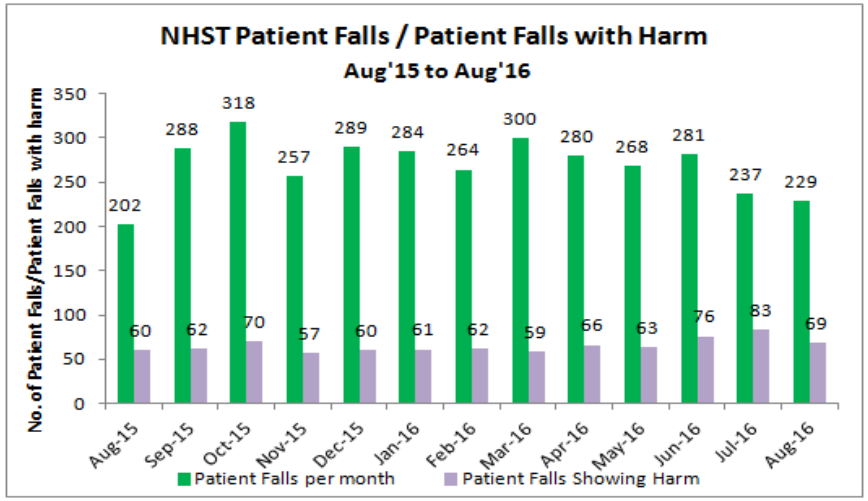
Rate per 1000 Bed Days of Unavoidable Pressure Ulcers



The information presented in respect of unavoidable pressure ulcers demonstrates that in the 13 months to August 2016 there has been 1 grade 4 pressure ulcer deemed as unavoidable, 7 grade 3 and 151 grade 2 pressure ulcers. The rate of avoidable pressure ulcers is consistently below 0.60 per 1000 bed days and remains within the upper and lower control limits.

All healthcare acquired grade 3 and 4 pressure ulcers are reviewed by the practice development nurse and opportunities for learning and reviewing practice are shared with the clinical team. All of the grade 2 pressure ulcers are reviewed by the clinical teams for learning and improvement and sharing of any learning takes place through the clinical governance performance reviews. By looking at all of the Datix incidents the practice development nurses can understand the profile of pressure ulcer development, identify areas of high incidence, and carry out focussed work within the teams. This process facilitates understanding of the educational needs of the nursing teams, and also identifies areas where new products or interventions are required. Within the hospital settings a suite of improvements based on best evidence in pressure ulcer prevention and care have been spread and embedded in to every day practice. All wards are expected to practice to the standards which are disseminated through policy, guidelines, and standardised documentation. Physical resources to prevent pressure ulcers are in the main provided by good nursing practice, and a range of devices readily available in all wards. The provision of ongoing education and maintaining a high profile of education, with visible leadership engagement in the improvement activity is paramount the provision to success.

Falls/Falls with Harm - Incidents



Through the Directorate Performance Reviews and local clinical governance groups, falls incidents are reviewed regularly to support identification of any trends, learning opportunities and service improvements.

It has been noted that there is likely an over-reporting of falls with harm as described within nationally agreed criteria. Work is underway to change the report format for reporting falls within Datix to address this matter.

Data Quality Definitions **Board Performance Update, as at end August 2016**

Measure	Definition	Data Source	Data Validation	Time Period Reported
Coding within 6 weeks of month end	Healthcare data for individual patients is collected as a series of Scottish Morbidity Records (SMR). The national target for SMR timeliness/completeness is that 95% of SMR's to be submitted to ISD within 6 weeks of month end to which the data relates. Clinical coding staff translate details in discharge summaries into codes (diagnostic information into ICD10, operations/procedures into OPCS4, 5) for SMR's. Once coding is complete the record is validated and is extracted on a weekly basis to ISD. Data is provided for SMR01 – Acute Inpatient and Day cases, SMR02 Maternity and SMR04 Mental Health	TOPAS	Once coding is complete (6 weeks) the record is validated and is extracted on a weekly basis to ISD.	July 2016
Ethnicity Recording	There is no national target set for collection of ethnicity, but it is mandatory to ask and record patients' ethnicity on TOPAS. NHS Tayside has set a local target of 95% for the % of SMR01 activity with ethnicity recorded. Data is provided for SMR00 – Outpatients and SMR01 – Acute Inpatient and Day case activity. Records where '98' = refused/not provided or '99' = not known are recorded are excluded from the calculation.	TOPAS	Validated data is available 6 weeks after the month end to allow for clinical coding to be completed.	July 2016

DATA QUALITY — Board Performance Update, as at end August 2016

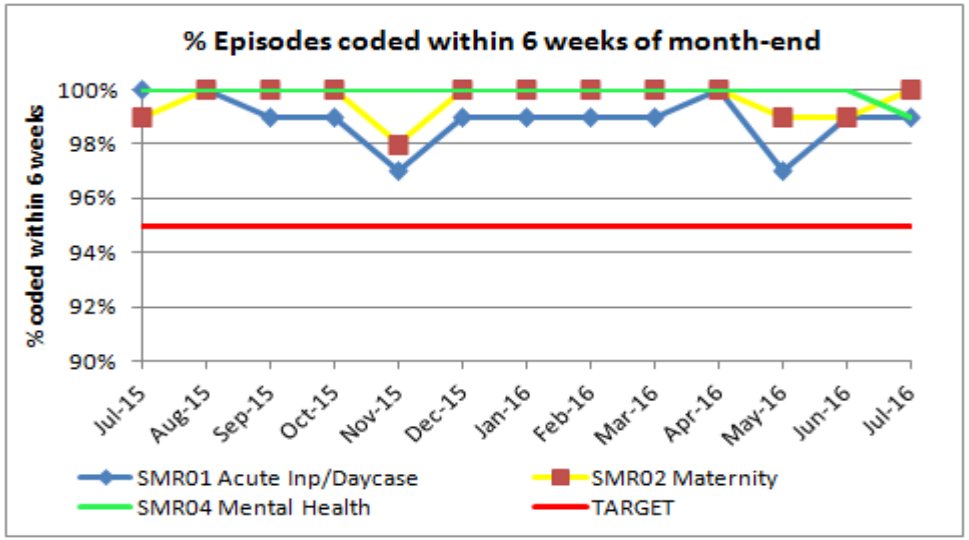
Improved performance ↑	Same performance ↔	Worse performance ↓

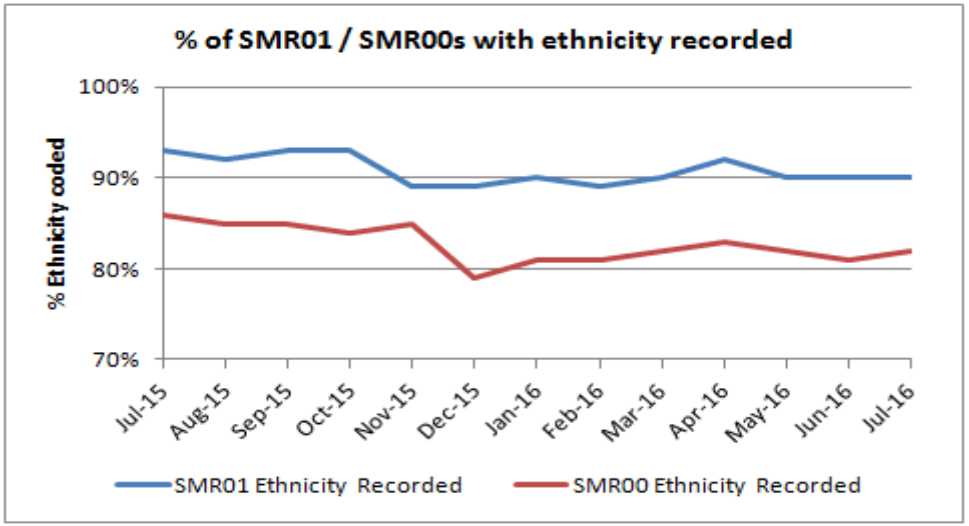
Coding within 6 weeks of month-end

	May-16	*Jun-16*	***Jul-16***	*Target*	*Performance*	*On Track*
% of Acute Inpatient/Daycase Episodes (SMR01) coded < 6 weeks of month-end	97%	99%	**99%**	95%	↔	✓
% of Maternity Episodes (SMR02) coded < 6 weeks of month-end	99%	99%	**100%**	95%	↑	✓
% of Mental Health Episodes (SMR04) coded < 6 weeks of month-end	100%	100%	**99%**	95%	↓	✓

Ethnicity recording

	May-16	*Jun-16*	***Jul-16***	*Target*	*Ranking*	*Performance*	*On Track*
% of SMR01 Activity with Ethnicity Recorded	90%	90%	**90%**	95%	*2nd*	↔	x
% of SMR00 Activity with Ethnicity Recorded	82%	81%	**82%**	95%	*2nd*	↑	x





Analysis

Clinical Coding

SMR data is expected to be received by ISD 6 weeks (42 days) following the end of the month of discharge / clinic date. ISD set a completeness target of 95% for Boards as there is an appreciation that there are valid reasons why information is not available within the timescales to produce good quality clinical coding.

There was a high level of performance in June and July 2016 all 2 SMR areas achieving a minimum of 99%, the national target being 95%.

Ethnicity

It was previously noted that the reduction in recording of ethnicity was due to the new methodology for recording ethnicity implemented in November 2015. The level of improvement in attainment noted has been held for both SMR00 and SMR01 in July 2016.

Rankings - Please note these apply to the March'16 position across Scotland, excluding Island Boards.

Feedback and Complaints — Board Performance Update, as at end August 2016

Measure	Definition	Data Source	Data Validation	Time Period Reported
Complaints Responded to within 20 days	Measures the percentage of all complaints closed in the reporting months that were closed within 20 working days of being opened.	Datix / Qlikview	Complaints information is validated on a quarterly basis for submission to ISD	July 2016
Complaints Acknowledged within 3 days	Measures the percentage of all complaints received in the reporting months that were acknowledged within 3 working days of receipt.	Datix / Qlikview	Complaints information is validated on a quarterly basis for submission to ISD	July 2016
Feedback Received	The total number of complaints, compliments, concerns and enquiries received each month	Datix / Qlikview	Complaints information is validated on a quarterly basis for submission to ISD	August 2016
Complaints Rate per 1,000 Activity	Measures the volume of complaints received calculated as a rate per 1,000 of total activity undertaken within NHS Tayside. The total activity figures include Outpatients appointments, Inpatient / Daycase stays and Day patient attendances including Mental Health and AHP activity.	Datix / TOPAS/ Qlikview	Complaints information is validated on a quarterly basis for submission to ISD	August 2016

Feedback and Complaints — Board Performance Update, as at end August 2016

Improved performance	↑	Same performance	↔	Worse performance	↓
Increasing Numbers	↑	Same Numbers	↔	Decreasing Numbers	↓

Feedback and Complaints	*May-16*	*Jun-16*	***Jul-16***	*Target*	*Performance*	*On Track*
Complaints Responded to within 20 working days	39%	44%	**51%**	68%	↑	x
Complaints Acknowledged within 3 working days	95%	96%	**97%**	80%	↑	✓
	Jun-16	*Jul-16*	***Aug-16***	*Target*	*Trend*	*On Track*
Number of all types of feedback received	185	155	**204**	-	↑	n/a
Number of complaints received	113	87	**136**	-	↑	n/a
Rate of Complaints per 1000 activity				-	↑	n/a

The board are advised that whilst figures are validated on a monthly basis, a final quarterly validation is undertaken approximately one month following quarter end which can result in some minor variations to the reported position

Figure 1 – % of complaints responded to within 20 working days

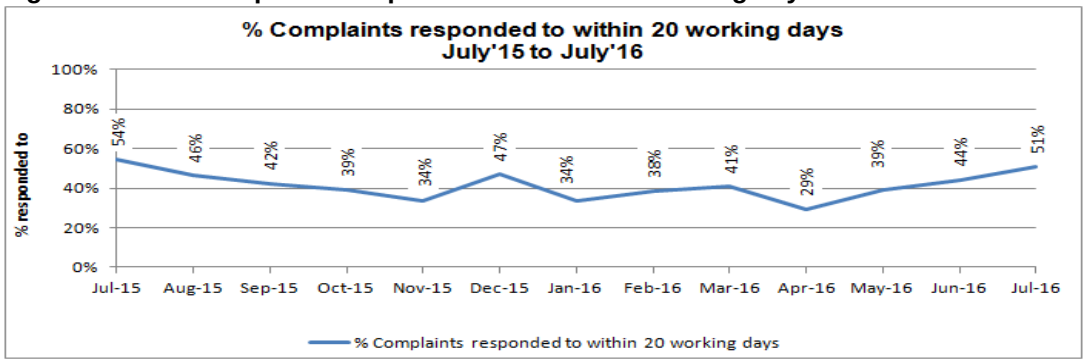
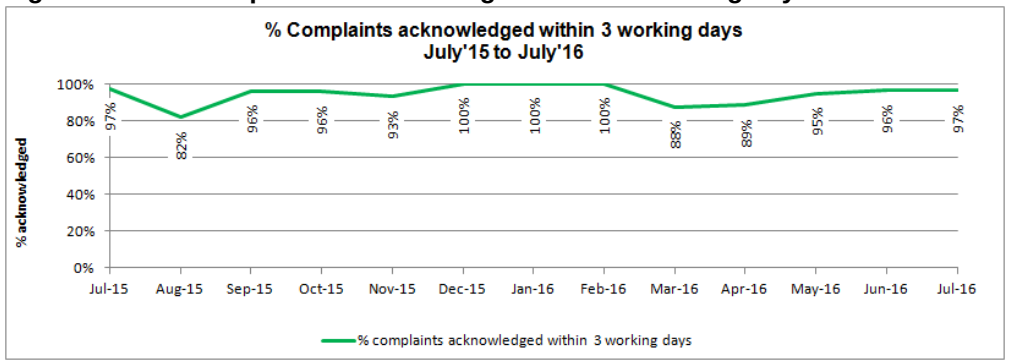


Figure 1 demonstrates NHS Tayside's timeliness of complaint responses. The 2014/15 NHS Complaints Statistics, Scotland, demonstrated that nationally, 69.6% of complaints were responded to within 20 days. For the most recent reportable month of July 2016, NHS Tayside achievement was 51% compliance.

Figure 2 - % of complaints acknowledged within 3 working days



Acknowledging complaints within 3 days improved in July 2016, achieving 97%.

Please note a review of previous months has led to updating of Public holiday calculations for some months which has resulted in improved attainment for the months affected.

Figure 3 – All Feedback Received (Complaints, Compliments, Concerns & Enquiries

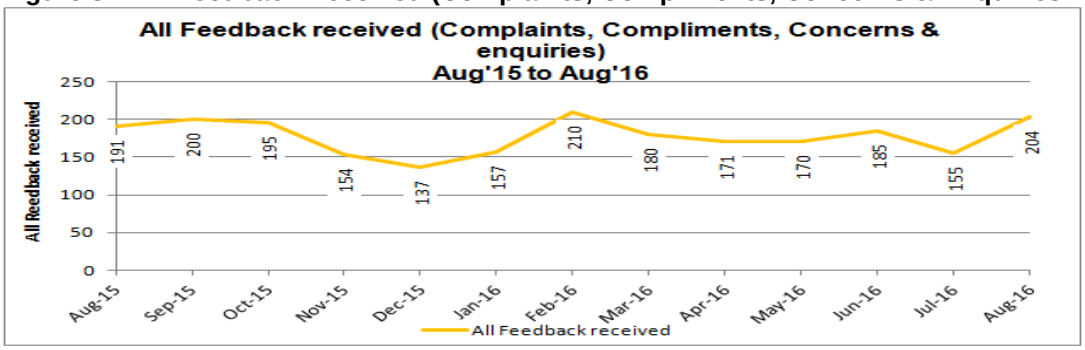
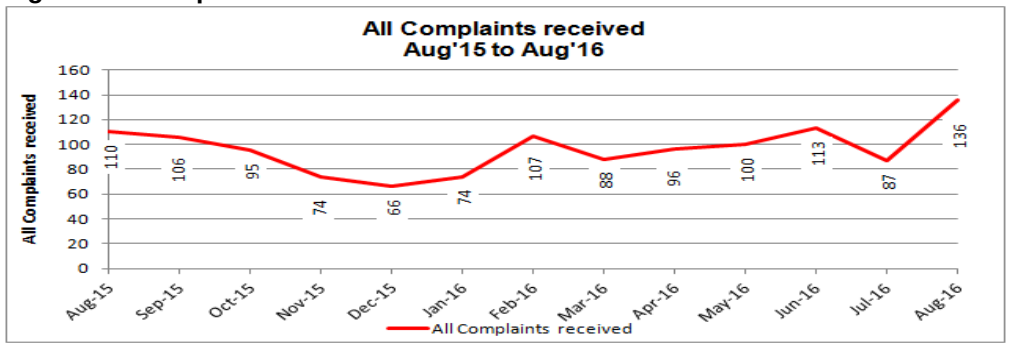


Figure 4 – Complaints Received



There has been an increase in the number of complaints received over August 2016 (figure 4) at 136 complaints compared to 87 received in July 2016. The volume of complaints received from the Prison Services increased from 17 in July 2016 to 32 in August 2016. 32 of the 41 Perth & Kinross CHP complaints received in Aug'16 were from the Prison Service.
The Executive Nurse Director and Chief Operating Officer have commissioned a refresh of the complaints handling process in NHS Tayside led by Dr Dorothy Armstrong, Professional Advisor to the Scottish Public Services Ombudsman.

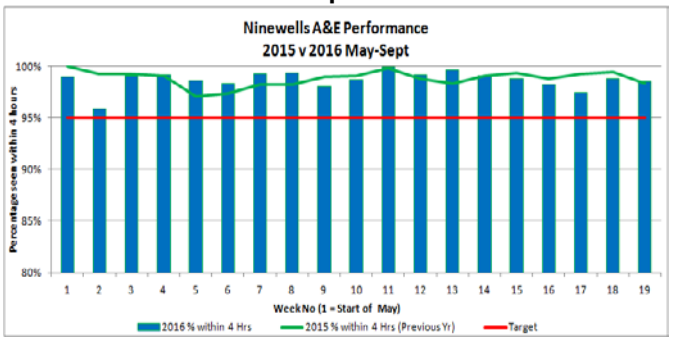
Unscheduled Care Measures	Board Performance Update, as at end August 2016

Measure	Definition	Data Source	Data Validation	Time Period Reported
A&E Attendances & 4 Hour Attainment	Number. of A&E Unplanned Attendances Number of A&E Unplanned Attendances seen within 4 Hours	Symphony	Validated data is available 2 days after the end of each week	Week ending 4th September 2016
Unscheduled Admissions/Discharges	Number of Unscheduled Admissions & Discharges Discharged from Ninewells or PRI and from Specialty Medical or Surgical only	TOPAS via Business Objects	Validated data is available 6 weeks after the month end to allow for clinical coding to be completed.	Week ending 4th September 2016
Unscheduled Admissions; Actual vs. Predicted	Number of Actual Unscheduled Admissions (SW) compared with the predicted number of Unscheduled Admissions (SW)	System Watch (SW)	Nationally produced and validated data	Week ending 4th September 2016
Patients awaiting an available bed in a ward	No. of patients awaiting an appropriate bed in a ward Both Ninewells or PRI and Medical or Surgical	Ward Staff in Ninewells and PRI	Local validation daily by ward staff	Week ending 4th September 2016
Length of Stay	Average of full Length of Stay of Discharges for patients who had an unscheduled admissions only Discharged from Ninewells or PRI and from a Surgical or Medical Specialty only	TOPAS via Business Objects	Validated data is available 6 weeks after the month end to allow for clinical coding to be completed.	Week ending 4th September 2016
Elective cancellations due to Bed Pressures	Number of patients booked as an Elective Inpatient or Daycase cancelled at short notice due to bed pressures Both Ninewells or PRI and Medical or Surgical	Services (normally Waiting List Co-ordinators)	Local validation weekly by each directorate	Week ending 4th September 2016

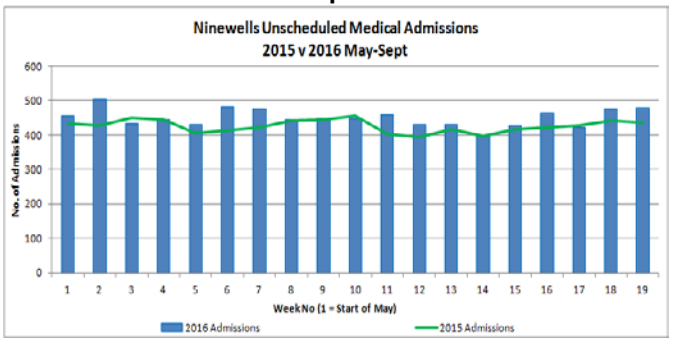
NINEWELLS			Week ending						Week ending		
Measures			*21/08/2016*	*28/08/2016*	*04/09/2016*	**Measures**			*21/08/2016*	*28/08/2016*	*04/09/2016*
A&E Attendances			980	996	1058	Medical– Average Length of Stay (Unscheduled)			4.1	3.8	3.6
A&E 4 Hour Attainment		**Graph (A)**	97.4%	98.8%	98.5%	Surgical–Average Length of Stay (Unscheduled)			5.7	5.6	6.7
Unscheduled Medical Admissions/Discharges		**(B)**	423/401	475/465	478/427	Patients awaiting an available bed in a ward	Medical & Surgical		0	26	4
Unscheduled Surgical Admissions/Discharges		**(C)**	224/232	235/227	224/220						
SystemWatch Unscheduled Admissions actual/predicted	Medical	**(D)**	373/383	403/366	398/369	Elective Cancellations – due to bed pressures	Medical	**(F)**	0	0	0
	Surgical	**(E)**	181/197	202/201	188/201		Surgical	**(F)**	0	0	0

The range of measures in place for monitoring capacity and flow at Ninewells are summarised in the table above and a comparison with the same period during 2015 is provided for some of these measures within the graphs below. The information demonstrates that A&E performance remains above standard, whilst emergency admission volumes are slightly higher than last year. Cancellations due to bed pressures continue to be lower than last year.

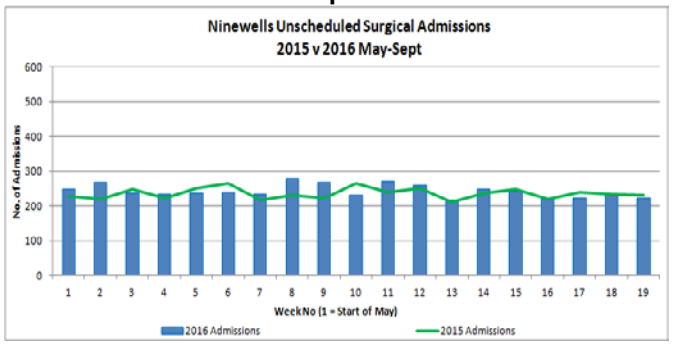
Graph A



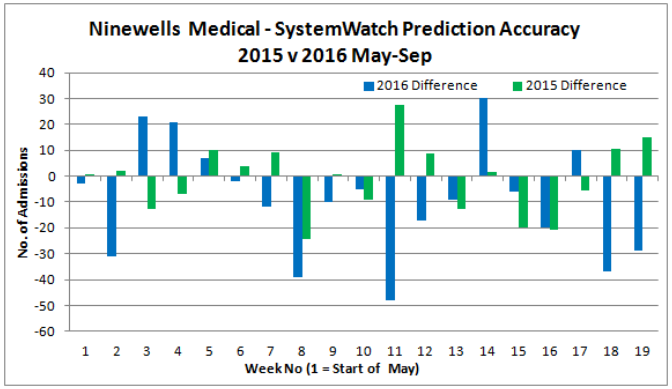
Graph B



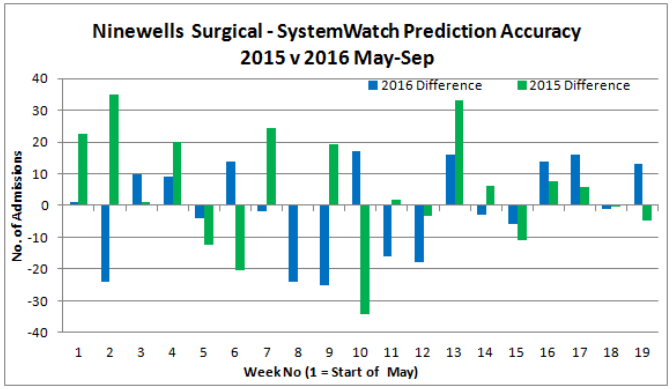
Graph C



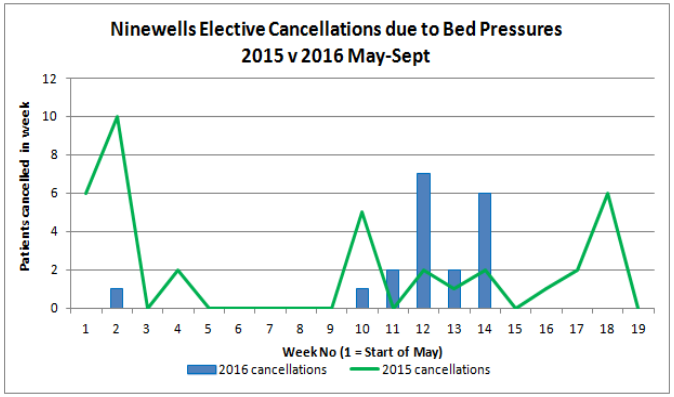
Graph D



Graph E



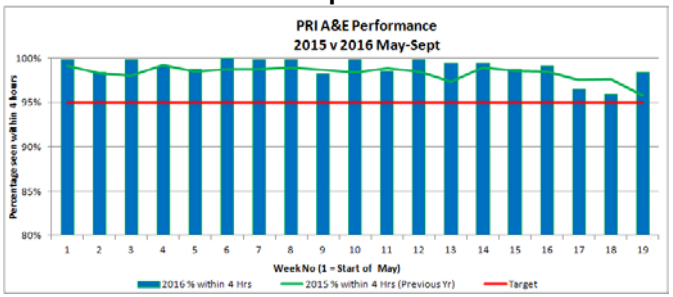
Graph F



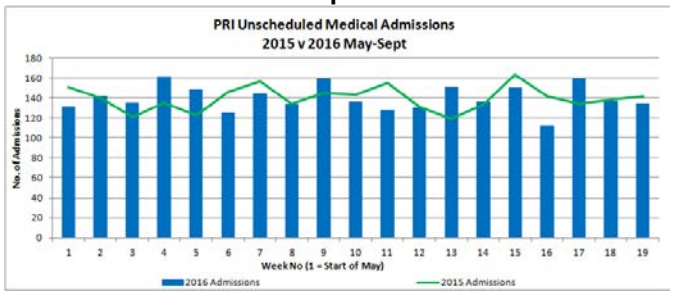
PRI			Week ending					Week ending		
Measures			*21/08/2016*	*28/08/2016*	*04/09/2016*	**Measures**		*21/08/2016*	*28/08/2016*	*04/09/2016*
A&E Attendances			536	519	485	Medical– Average Length of Stay (Unscheduled)		8.0	5.8	6.2
A&E 4 Hour Attainment		**Graph (A)**	96.5%	96.0%	98.4%	Surgical–Average Length of Stay (Unscheduled)		3.3	6.9	2.7
Unscheduled Medical Admissions/Discharges		**(B)**	159/125	137/141	134/122	Patients awaiting an available bed in a ward	Medical	10	14	4
Unscheduled Surgical Admissions/Discharges		**(C)**	41/42	42/36	45/40		Surgical	0	0	1
SystemWatch Unscheduled Admissions actual/predicted	Medical	**(D)**	147/127	130/127	131/131	Elective Cancellations - due to bed pressures	Medical **(F)**	0	0	0
	Surgical	**(E)**	43/52	45/53	46/51		Surgical **(F)**	0	0	0

The range of measures in place for monitoring capacity and flow at Perth Royal Infirmary are summarised in the table above and a comparison with the same period during 2014/15 is provided for some of these measures within the graphs below. As with Ninewells, the information demonstrates that A&E performance remains above standard, whilst emergency medical admission volumes have been variable in comparison to last year. The number of cancellations due to bed pressures continue to be lower than last year.

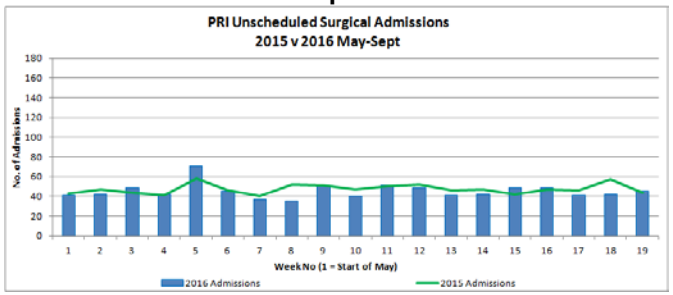
Graph A



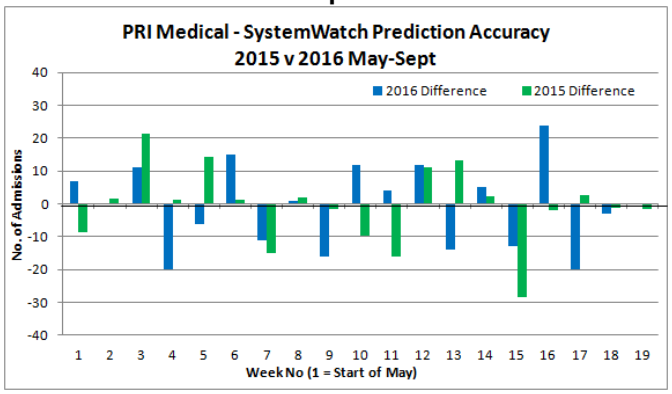
Graph B



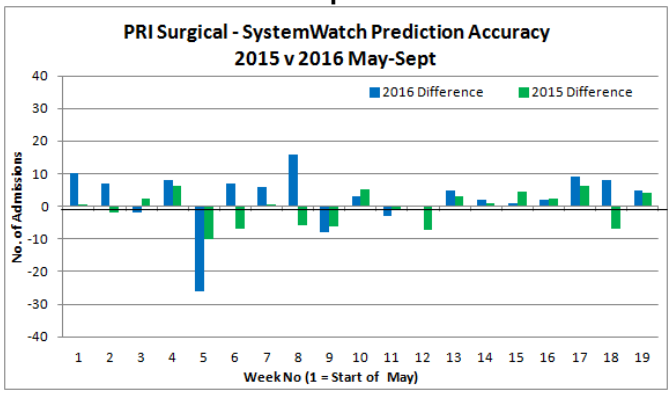
Graph C



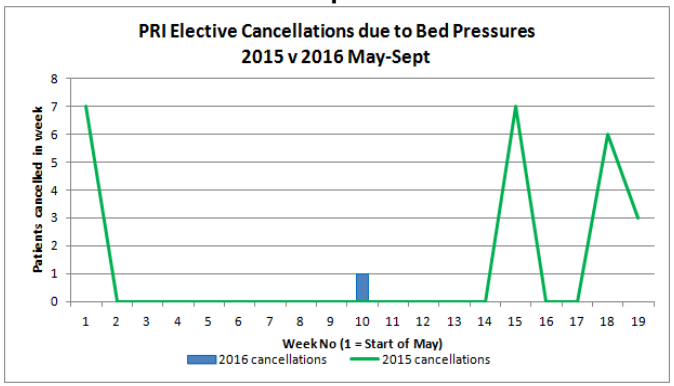
Graph D



Graph E



Graph F



Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item 8.4

BOARD110/2016
Tayside NHS Board
27 October 2016

UPDATE TO THE NHS TAYSIDE CODE OF CORPORATE GOVERNANCE
Section A – Remit of the Universities Strategic Liaison Committee

1. SITUATION AND BACKGROUND

The purpose of the report is to seek the Board's approval of an update to the Code of Corporate Governance, Section A, COMMITTEES, 8. Purpose and Remits, Universities Strategic Liaison Committee.

There has been ongoing discussion about the crossover between the Universities Strategic Liaison Committee (USLC) and the Academic Health Science Partnership (AHSP) and the possibility of the AHSP taking on the role of the USLC.

This is currently not possible following discussion it has been agreed that the terms of reference of the USLC should be updated and should have more representation from AHSP.

Arrangements are in hand for this to be discussed at the next meeting of the USLC scheduled to be held in November 2016.

2. ASSESSMENT

This update to the Code of Corporate Governance is attached to this report as appendix 1 and has been shared with the Corporate Governance Review Group and was recommended for Board approval at the Audit Committee meeting on 1 September 2016.

The Governance Review Group has the remit to oversee and co-ordinate the changes resulting to the Code of Corporate Governance.

The Audit Committee's role is to scrutinise the proposed update and to approve its recommendation to Tayside NHS Board. The Board retains the responsibility for approving any updates to the Code of Corporate Governance.

3. RECOMMENDATIONS

The Board is asked to approved the attached update to the Code of Corporate Governance

4. REPORT SIGN OFF

Ms M Dunning
Board Secretary

October 2016

Universities Strategic Liaison Committee

1.1 Purpose

The Committee will advise the Board on strategic matters concerning clinical teaching, research, ACT funding and facility requirements.

The Committee will provide an inclusive forum for strategic dialogue, development and planning between the Universities of Dundee, Abertay and St Andrews and with the NHS in Tayside and Fife.

1.2 Composition

Membership of the Universities Strategic Liaison Committee will be:

A minimum of four Non-Executive Members of Tayside NHS Board including:

- University of Dundee Member
- Employee Director
- Chair, Area Clinical Forum

Membership will also include:

- Chief Executive, NHS Tayside (Lead Officer)
- ~~One Non-Executive Member of NHS Fife~~
- 3 representatives from the University of Dundee covering Medicine, Nursing and Dentistry
- 2 representatives from St Andrews University covering Medicine and Nursing
- 2 representatives from Abertay University covering Medicine and Nursing
- 2 representatives from Fife NHS Board
- 1 representative NHS Education for Scotland
- 4 r~~R~~epresentatives from AHSP ~~– Tayside Research and Development Director~~
- ~~In addition there will be in attendance:~~
- ~~Director of Medical Education, NHS Fife~~

The Chair will be a Non Executive Member of Tayside NHS Board. The Vice-Chair will be a representative of one of the Universities.

Other Directors will only attend if they are presenting a report to the Committee or the Committee requests their attendance.

Formatted: Indent: Left: 1.25", Bulleted + Level: 1 + Aligned at: 0.25" + Tab after: 0.5" + Indent at: 0.5", Tab stops: 1.5", List tab + Not at 0.5"

1.3 Meetings

Meetings of the Committee shall be quorate when five or more Members are present, at least two of whom will be a Non-Executive Member of the Board.

1.4 Remit

To provide the opportunity for collaborative dialogue in relation to government policies and their impact within the region.

To provide a dialogue around the new 20/20 Workforce Vision.

To provide the opportunity for collaborative development and planning in relation to research and development in Healthcare.

To engage and inform future strategies for community health and social care and research.

Consider teaching and training resources for the next 5 years.

~~To feed outcomes into individual workplans for NHS Tayside and Universities.~~

To provide strategic guidance in developing models of healthcare.

1.5 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and is authorised to seek any information it requires from any employee.

In order to fulfil its remit, the Universities Strategic Liaison Committee may obtain whatever professional advice it requires, and require Directors or other officers to attend meetings.

1.6 Reporting Arrangements

The Universities Strategic Liaison Committee reports to Tayside NHS Board.

Following a meeting of the Universities Strategic Liaison Committee, the minutes of that meeting should be presented at the next Tayside NHS Board meeting.

The Universities Strategic Liaison Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Universities Strategic Liaison Committee.

The Universities Strategic Liaison Committee will produce an Annual Report for presentation to the Audit Committee. The Annual Report will describe the outcomes from the Committee during the year and provide an assurance to the Audit Committee that the Committee has met its remit during the year. The Annual Report must be approved by the Universities Strategic Liaison Committee before it is presented to the Audit Committee meeting considering the Annual Accounts.

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item 8.5

BOARD111/2016
Tayside NHS Board
27 October 2016

BEST VALUE FRAMEWORK 2016/17

1. PURPOSE OF THE REPORT

The purpose of the report :

- To present the revised Best Value Framework 2016/17 for approval by the Board

2. RECOMMENDATIONS

The Board is asked to:

- Approve the Best Value Framework 2016/17 as attached in Appendix 1

3. EXECUTIVE SUMMARY

Best Value guidance requires that NHS Tayside is able to demonstrate through its assurance and self-assessment processes how Best Value attributes and practices are embedded within the way it works and how continuous improvement is achieved and monitored.

The Framework is based on the Best Value guidance and also incorporates relevant elements of the Governance Statement guidance, Good Governance Principles for Public Life (Langlands), Public Sector Internal Audit Standards, Governance for Quality, Scottish Public Finance Manual, IJB Governance Checklists and Local Authority Best Value Guidance.

4. REPORT DETAIL

The Best Value Framework for 2016/17 is attached as Appendix 1.

The Best Value Framework was updated to take account of the findings of Internal Audit Report T11/16 Best Value and comments previously highlighted by Board Members when the Board's Best Value Assurance Report was presented to the Board earlier in the year.

The Audit Committee gave detailed consideration to the Best Value Framework at its meeting on 1 September 2016. The Committee noted that the Framework had been updated to allow conclusions to be shown for the outcome/evidence such as "in place", "partially in place", or "not demonstrated in year" as well as any further work planned for the future to address identified gaps. This was felt to be beneficial as it gave a more accurate assessment.

The Committee also noted the measures/expected outcomes and the Standing Committee that would be responsible for consideration of these. However, they were of the view that the areas delegated to the Transformation Programme Board should be relooked at recognising the role of the Standing Committees.

As part of the Best Value process, the Board and Standing Committees will need to ensure that

they fulfil their individual responsibilities for Best Value by incorporating the relevant sources of evidence into their work plans for the year. This then forms part of the overall conclusion on those Best Value characteristics elements delegated to them within their annual report for 2016/17.

The Board Secretary and Head of Committee Administration supported by Internal Audit are taking forward meetings with the Lead Officers, Chairs and Vice Chairs of the Standing Committees to discuss the Best Value Framework and the implications for their work plans.

These meetings are being arranged with the first to take place with the Finance and Resources Committee on 1 November 2016. This will assist in scheduling the work of the Committees and help to determine whether the organisation is achieving continuous improvement and Best Value.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

The functions of Tayside NHS Board include strategic leadership and direction and relate to Best Value Characteristic 1, Vision and Leadership.

6. MEASURES FOR IMPROVEMENT

Best Value Characteristic 5 focuses on performance management and a Best Value organisation is one that embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement on performance and outcomes.

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

Equality is integral to all our work as demonstrated by its positioning as a cross- cutting theme in the Best Value Framework for Allocating Best Value Characteristics. Public Bodies have a range of legal duties and responsibilities with regard to equality.

A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

8. PATIENT EXPERIENCE

A Best Value organisation will show how it, and its partnerships, are displaying effective collaborative leadership in identifying and adapting their service delivery to the challenges that clients and communities face.

9. RESOURCE IMPLICATIONS

Financial
There are no financial implications.

Workforce
There are no workforce implications.

10. RISK ASSESSMENT

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours.

The monitoring against the Best Value Framework will provide an assurance that the

organisation has robust processes and procedures in place along with a suitable focus on continuous improvement.

11. LEGAL IMPLICATION

There are no legal implications.

12. INFORMATION TECHNOLOGY IMPLICATIONS

There are no IT implications.

13. HEALTH & SAFETY IMPLICATIONS

There are no Health & Safety implications.

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no Healthcare Associated Infection implications.

15. DELEGATION LEVEL

The Board approves the Framework for Allocating the Best Value Characteristics delegates work to achieve this to its Committees.

16. TIMETABLE FOR IMPLEMENTATION

Immediate implementation

17. REPORT SIGN OFF

Ms M Dunning
Board Secretary

Ms L McLay
Chief Executive

October 2016

18. SUPPORTING DOCUMENTS

Appendix 1 - Best Value Framework 2016/17

Appendix 1

Tayside NHS Board
Best Value Framework 2016/17

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
Executive and Non-Executive leadership demonstrate a commitment to high standards of probity and integrity including the Nolan principles.	Tayside NHS Board members sign up to the Members Code of Conduct in the NHS Tayside's Code of Corporate Governance.	**BOARD**	Annual		
NHS Tayside acts in accordance with its values, positively promotes and measures a culture of ethical behaviours and encourages staff to report breaches of its values.	Culture Diagnostics Toolkit Whistle blowing Policy	**BOARD** **STAFF GOVERNANCE COMMITTEE**	Annual On review as required		
NHS Tayside can demonstrate that continuous improvement is incorporated into its strategy and plans.	The inclusion of trajectories against the HEAT Targets will demonstrate continuous improvement.	**BOARD**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
NHS Tayside has defined quality standards for its outcomes.	NHS Tayside's Clinical Governance Measurement & Monitoring Framework	**CLINICAL AND CARE GOVERNANCE COMMITTEE**	Regular reporting		
Non-executive members are discriminating about getting involved in matters of operational detail.	Non–executive members are visible in the organisation dealing with strategic and governance issues.	**CHAIRMAN**	Annual	Annual Appraisal	
Resources required to achieve the strategic plan and operational plans e.g. finance, staff, asset base are identified and additional/changed resource requirements identified.	Strategic Financial Plan, Workforce Plan and PAMS. 5 year Strategic transformational plan	**FINANCE AND RESOURCES / STAFF GOVERNANCE COMMITTEE** **BOARD T**	Annual		
The Board agrees a strategic plan which incorporates the organisations's vision and values and reflects stated priorities.	5 year Strategic transformational plan	**BOARD**	Every five years		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
The strategic plan and operational plans are based on relevant, reliable and sufficient evidence.	Business Unit to feed into development of the 5 year Strategic transformational plan. LDP based on data	**BOARD** **BOARD**	Every five years Annually		
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Annual operational plan underlying the 5 year strategic transformational plan.	**BOARD**	Annual		
The Board has identified the risks to the achievement of its strategic and operational plans are identified together with mitigating controls.	Each strategic risk has an Assurance Framework which maps the mitigating actions/risks to help achieve the strategic and operational plans. Assurance Framework contains the overarching strategic risks related to the strategic plan.	**BOARD**	Three times per year		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
The Board has clearly recorded delegation to Committees and management.	The Board has established terms of reference for its Committees and has a Scheme of Delegation.	**BOARD**	Every two years	Code of Corporate Governance	
The Board of governance has defined its purpose, role and responsibilities and recorded how these will be fulfilled.	Tayside NHS Board's purpose role and responsibilities are clearly set out in NHS Tayside's Code of Corporate Governance.	**BOARD**	Every two years	Code of Corporate Governance	
The organisation's strategy is communicated effectively to all staff and stakeholders.	A communication and engagement strategy to be developed during 2016/2017.	**BOARD**	Every three years		
There are mechanisms within the organisation to develop and monitor relevant leadership and strategic skills in Board members and senior management.	This is achieved through the development of Personal Development Plans and Annual Appraisals.	**CHAIRMAN/CHIEF EXECUTIVE**	Annual		

EFFECTIVE PARTNERSHIPS

The "Effective Partnerships" theme focuses on how a Best Value organisation engages with partners in order to secure continuous improvement and improved outcomes for communities, not only through its own work but also that of its partners.

OVERVIEW

A Best Value organisation will show how it, and its partnerships, are displaying effective collaborative leadership in identifying and adapting their service delivery to the challenges that clients and communities face. The organisation will have a clear focus on the collaborative gain which can be achieved through collaborative working and community engagement in order to facilitate the achievement of its strategic objectives and outcomes.

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year**	**Comment (Future work planned?)**
The Board develop relationships and works in partnership wherever this leads to better service delivery. The organisation seeks to explore and promote opportunities for efficiency savings and service improvements through shared service initiatives with partners	NHS Tayside involvement in IJB Strategic Commissioning plans.	**BOARD**	As required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
Clear governance arrangements are in place in respect of partnerships and other group-working. Responsibilities and reporting lines in respect of all governance arrangements have been clarified agreed by all parties and reflected in NHS Tayside's Code of Corporate Governance and the structure of assurance	All reports to the Board where appropriate should explicitly detail whether partnership working has been considered. Where partnership arrangements are in place the reports should detail the performance management and governance arrangements. Input into the IJB Strategic Plans and IJB performance arrangements to be agreed with IJBs and the Board.	**BOARD**	As required		
In joint working with any partners the Board works openly to an agreed vision, objectives and performance management and reporting mechanisms	NHS Tayside involvement in IJB Strategic Commissioning plans.				

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure openness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
The Board has identified its stakeholders and understands its relationships with them.	Corporate communications and engagement strategy (to be developed).	**BOARD**	By 31 March 2016		
The Board understands citizen, patient, staff partner and stakeholder views, perceptions, and expectations.	Board reports should show evidence of the views of its stakeholders.	**BOARD**	As required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
These views inform strategic and operational plans, priorities and actions.	Communication & Engagement Strategy for Transformation Programme. The links between the engagement outcomes and the strategy / operational plans should be evident in Impact Assessments and full 'for decision' template Board Reports.	**BOARD**	As required		
Board and Committee decision-making processes are open and transparent.	Board and Committee meetings are held in open session and minutes are publically available.	**BOARD/ COMMITTEES**	On going		
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD/ COMMITTEES**	As required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside has a robust framework of corporate governance to provide assurance to relevant stakeholders that there are effective internal control systems in operation which comply with the SPFM and other relevant guidance.	Explicitly detailed in the Governance Statement.	**AUDIT COMMITTEE**	Annual		
The performance of the Board is self-assessed and appropriate actions identified and implemented as required.	Board diagnostic toolkit and Best Value Framework	**BOARD**	Annual		
The performance of non-executive Directors is regularly evaluated.	Non-executives appraisals	**CHAIRMAN**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside regularly conducts rigorous review and option appraisal processes of all areas of activity, develops and develops and monitors action plans for any required improvements.	Transformation Programme	**BOARD FINANCE AND RESOURCES COMMITTEE**	As required		
NHS Tayside has developed and implemented an effective and accessible complaints system in line with Scottish Public Services Ombudsman guidance.	Complaints system in place and regular complaints monitoring.	**CLINICAL AND CARE GOVERNANCE COMMTTEE**	Ongoing		
NHS Tayside can demonstrate that it has clear mechanisms for receiving feedback from service users and responds positively to issues raised.	An annual feedback report is published.	**CLINICAL AND CARE GOVERNANCE COMMITTEE**	Annual		

Formatted: Not Highlight

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside can demonstrate that it has clear mechanisms for receiving feedback from staff and responds positively to issues raised.	To be reported to the Staff Governance Committee as part of the reporting around 'I Matter'. Staff survey results reported to Staff Governance Committee.	**STAFF GOVERNANCE COMMITTEE**	Annual		

USE OF RESOURCES

The "Use of Resources" theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside understands and measures and reports on the relationship between cost, quality and outcomes.	Transformation Programme	**BOARD FINANCE AND RESOURCES COMMITTEE**	As required		
The organisation has a comprehensive programme to evaluate and assess opportunities for efficiency savings and service improvements including comparison with similar organisations.	National Benchmarking undertaken through Corporate Finance Network. Local bencmarking with similar sized organisation undertaken where information available. Participation in National Shared Services.	**FINANCE AND RESOURCES COMMITTEE**	As required	e.g theatres benchmarking work and potential roll out	

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
Organisational budgets and other resources are allocated and regularly monitored.	Corporate Finance Reports and Capital reports.	**FINANCE AND RESOURCES COMMITTEE**	Every meeting		
NHS Tayside has a strategy for procurement and the management of contracts (and contractors) which complies with the SPFM and demonstrates appropriate competitive practice.	Procurement updates to Finance and Resources Committee. Delegated authority and waiver of competitive tendering reported to each Finance and Resources Committee.	**FINANCE AND RESOURCES COMMITTEE**	Twice per year and as required		
NHS Tayside maintains an effective system for financial stewardship and reporting in line with the SPFM.	Annual Accounts process.	**AUDIT COMMITTEE**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
There is a robust information governance framework in place that ensures proper recording and transparency of all NHS Tayside's activities.	Information Governance Committee Annual Report.	**FINANCE AND RESOURCES COMMITTEE**	Annual		
NHS Tayside understands and exploits the value of the data and information it holds.	Business Unit data informs transformation programme. Performance information reported to Board/Committees is validated.	**BOARD RELEVANT STANDING COMMITTEES**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside ensures that all employees are managed effectively and efficiently, know what is expected of them, their performance is regularly assessed and they are assisted in improving.	EKSF process and Executive and Senior Manager Performance reporting. Medical performance appraisal.	**STAFF GOVERNANCE COMMITTEE/ REMUNERATION COMMITTEE**	Annual and as required		
NHS Tayside understands and measures the learning and professional development required to support statutory and professional responsibilities and achieve organisational objectives and quality standards.	Medical revalidation report and monitoring Nursing revalidation.	**STAFF GOVERNANCE COMMITTEE**	As required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
Staff performance management recognises and monitors contribution to ensuring continuous improvement and quality.	Service Improvement and Quality are core dimensions of EKSF process. Executive and Senior Manager Objectives – core collective objectives include performance and leadership.	**STAFF GOVERNANCE COMMITTEE/ REMUNERATION COMMITTEE**			
Fixed assets including land, property, ICT, equipment and vehicles are managed efficiently and effectively and are aligned appropriately to organisational strategies.	Property and Asset Management Strategy	**FINANCE AND RESOURCES COMMITTEE**			

PERFORMANCE MANAGEMENT

The "Performance Management" theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year**	**Comment (Future work planned?)**
Performance is systematically measured across all key areas of activity.	The Board delegates to Committees the performance reporting for key areas of activity. Board receives regular performance reports.	**COMMITTEES/ BOARD**	As required Every meeting		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
The Board and its Committees approve the format and content of the performance reports they receive which should include – Assess its performing against the following criteria: Performance reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	The Board/Committees reviews the performance reporting under its remit and agrees the measures.	**COMMITTEES/ BOARD**			
Performance reporting allows a reasonable and informed judgement on how the organisation is likely to perform in future.	Board performance report shows trends.	**BOARD**	Every meeting		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
Public performance reports show performance against: ◊ objectives, targets and service outcomes; ◊ past performance; ◊ improvement plans; ◊ other relevant bodies.					
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Board Minutes show scrutiny and challenge when performance is poor as well as good.	**BOARD**	Every meeting		
The Board has received assurance on the accuracy of data used for performance monitoring.	Board performance reporting information uses validated data.	**BOARD**	Every meeting		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Board's regular performance report and regular reporting on Local Delivery Plan.	**BOARD**	Every meeting and quarterly		
NHS Tayside has evidence that it has the necessary capacity and capability to deploy when performance is slow or weak	Where underperformance has been identified, resources are deployed as required.	**BOARD**	As required		
NHS Tayside prioritises performance improvements likely to have the greatest impact	Transformation Programme	**BOARD RELEVANT STANDING COMMITTEES**	As required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside overtly links Performance Management with Risk Management to support prioritisation and decision-making at Executive level, support continuous improvement and provide assurance on internal control and risk.	Board Assurance Framework	**BOARD**	Quarterly		
Clients, citizens and other stakeholders are involved in developing indicators and targets and monitoring and managing performance so that information provided is relevant to its audience	Participation standards Business cases developed in partnership for new or changed services.	**CLINICAL AND CARE GOVERNANCE COMMITTEE** **BOARD**			

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term.

The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make.

A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside can demonstrate that it is making a contribution to sustainable development by actively considering the social, economic and environmental impacts of activities and decisions both in the shorter and longer term.	Sustainability and Environmental report to Finance and Resources Committee during year and progress incorporated in the Annual Accounts process.	**FINANCE AND RESOURCES COMMITTEE**	Annual		
NHS Tayside can demonstrate that it respects the limits of the planets environment, resources and biodiversity in order to improve the environment and ensure that the natural resources needed for life are unimpaired and remain so for future generations.	Sustainability and Environmental report to Finance and Resources Committee during year and progress incorporated in the Annual Accounts process.	**FINANCE AND RESOURCES COMMITTEE**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside contributes to building a strong, stable and sustainable economy which provides prosperity and opportunities for all.	Annual Report of Healthcare Academy and reporting on modern apprenticeships.	**STAFF GOVERNANCE COMMITTEE**			
NHS Tayside promotes personal well-being, social cohesion and inclusion.		**BOARD**			
NHS Tayside has self-assessed and reported against the Public Bodies Climate Change Duties Guidance.	Part of Annual Accounts process.	**AUDIT COMMITTEE**			

CROSS-CUTTING THEME – EQUALITY

This section should be read in conjunction with guidance on the UK Equality Act 2010 which will become available in 2011.

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE: Fully in place/ Partially in place/ Not demonstrated in year**	**Comment (Future work planned?)**
NHS Tayside meets the requirements of equality legislation.	Regular reporting against NHS Tayside Mainstreaming Report and Equality Outcomes 2013-2017.	**CLINICAL AND CARE GOVERNANCE/ STAFF GOVERNANCE**	Twice per year		
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD/ COMMITTEES**	As required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE: Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside openly engages in a fair and inclusive dialogue to ensure information on services and performance is accessible to all.	Accessible Information document to be developed.	**BOARD**	As required		
NHS Tayside's Performance Management system regularly measures and reports its performance in contributing to the achievement of equality outcomes.	Regular reporting against NHS Tayside Mainstreaming Report and Equality Outcomes 2013-2017.	**CLINICAL AND CARE GOVERNANCE/ STAFF GOVERNANCE**	Twice per year		
NHS Tayside ensures that all members of staff are aware of its equality objectives.	Induction Equality and Diversity is core dimension in EKSF Equality and Diversity Learn Pro Module Equality and Diversity Champions.	**STAFF GOVERNANCE**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE: Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD/ COMMITTEES**	As required		
Wherever relevant, NHS Tayside collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD/ COMMITTEES**	As required		

Item 8.6

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

BOARD113/2016
Tayside NHS Board
27 October 2016

BOARD ASSURANCE FRAMEWORK (BAF)

1. PURPOSE OF THE REPORT

The purpose of this report is to present the Board Assurance Framework as at October 2016.

2. RECOMMENDATIONS

Members of Tayside NHS Board are asked to:

- Consider the Board Assurance Framework which includes the Strategic Risk Profile (Appendix A) and individual risk reports from DATIX (Appendix B)
- Note the updates in respect of the Health and Social Care Partnerships; Managed/2C Practice; Implementation of TrakCare and Sustainability of Primary Care Strategic Risks
- Acknowledge that Operational Risks will be considered and reviewed as part of the Strategic Risk Reports to Standing Committees
- Request any additional reports/information they consider necessary

3. EXECUTIVE SUMMARY

The Board Assurance Framework Strategic Risk Profile – (Appendix A) and individual risk reports from DATIX (Appendix B) aims to identify the Strategic Risks that could impact on the delivery of NHS Tayside's objectives. It sets out the controls that have been put in place to reduce or mitigate (manage) the risks and the assurances that have been received which show if the controls are having the desired impact. It includes an action plan, which details mitigating actions to be taken, to further reduce the risks and an assessment of current performance is also provided.

4. REPORT DETAIL

Within NHS Tayside all key risks are divided into one of three categories of either Strategic, Operational or Service Level Risk.

Strategic Risks are risks which are at the highest level within the Organisation and are always owned by an Executive Director. These are agreed and then monitored by the Strategic Risk Management Group and reported to Tayside NHS Board on a quarterly basis with progress reports given to the most appropriate Standing Committee of Tayside NHS Board four times per year. They are also linked to the NHS Tayside Corporate Objectives.

Operational Risks are the suite of 5 or 6 risks which directly relate to the achievement of all strategic risks. These are identified by the Executive Director who owns the strategic risk and while these are also owned by an Executive Director they will be managed by a nominated member of staff. These must be agreed by the Strategic Risk Management Group and linked to a parent strategic risk.

All other risks are known as **Service Level Risks** and are owned by a member of staff, who has participated in a risk management workshop and received Datix Risk Module User Training, within NHS Tayside. These service risks should be identified as part of a group activity and agreed by Directorate Clinical Governance and Risk Fora who will thereafter review these as portfolios of risk.

All activities are carried out with a view to achieving an objective – be it safe patient care, delivery of an effective service or maintaining a budget for example – and the risk should be in relation to failure to meet that objective or opportunities for innovation, change or improvement related to the objective.

Since the Board Assurance Framework was last considered by Tayside NHS Board on 23 June 2016, it has been discussed at one meeting of the Strategic Risk Management Group (SRMG) on 15 August 2016. At this meeting the risk owners provided exception reports in relation to each of the strategic risks facing NHS Tayside.

At this meeting a proposal, which had previously been endorsed by Internal Audit colleagues, suggesting that operational risks be included as part of the Strategic Risk updates to either Tayside NHS Board or the relevant standing committee was agreed.

Progress has been made in relation to the following Strategic Risks:

Health and Social Care Partnerships –The Strategic Risk was reviewed, updated and archived by the Risk Owner.

Managed/2C Practices – The drafting of this risk has now been completed and agreed and subsequently added to Datix on 11 August 2016.

Implementation of TrakCare: The drafting of this risk has also now been completed and agreed and subsequently added to Datix on 17 August 2016

Development and Sustainability of Primary Care: This Strategic Risk has been reviewed and updated and now has a focus on the Sustainability of Primary Care.

No new Strategic Risks were raised or identified during the process of horizon scanning.

The Board Assurance Framework as at October 2016 is attached to this report comprising of the current Strategic Risk Profile - Appendix A and the individual risk reports as per the DATIX system - Appendix B.

Following the Board approval of a new Assurance Report template the Standing Committees and the Board are now routinely receiving these Assurance Reports on the Strategic Risks aligned to them. This template will be updated to allow detail about the underpinning operational risks to be included as part of the report.

Work has commenced in relation to the development of a new suite of Key Performance Indicators for risk management and is planned around the further develop NHS Tayside's Risk Appetite and Risk Appetite statement. Internal Audit and Doug Cross, Non-Executive Member have agreed to input to the development of these along with the Board Secretary, Risk Manager and the Head of Committee Administration.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

The functions of Tayside NHS Board include strategic leadership and direction and to ensure efficient, effective and accountable governance of NHS Tayside a robust set of risk management arrangements allow these to be achieved.

6. MEASURES FOR IMPROVEMENT

Within NHS Tayside a series of Measures for Improvement/Key Performance Indicators have been developed and agreed for Risk Management as identified within the Risk Management Strategy.

Additionally, Performance Reviews contain a series of Measures for Improvement for all Directorates/CHPs and are included in the Clinical Governance & Risk Management Reports for each Directorate/CHPs.

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

All risks influenced by any equity and diversity issue will have an impact assessment undertaken.

Consultation and involvement was undertaken with the Board Secretary to produce this paper.

8. PATIENT EXPERIENCE

Clinical Governance and Risk Management systems and processes are embedded across NHS Tayside. This ultimately contributes to the patient experience by reviewing adverse events, implementing improvements and minimising risk exposures across all services. There is also a drive to ensure that patients and/or their families are advised when an adverse events occurs during their care and are kept updated on any actions taken to improve the service and reduce the likelihood of the adverse event recurring.

9. RESOURCE IMPLICATIONS

Financial and Workforce
The system arrangements for Clinical Governance and Risk Management are contained within current resource.

10. RISK ASSESSMENT

This paper links directly with the Clinical Governance Strategic Risk which encompasses Risk Management systems and process and is recorded within the DATIX system graded as High/Amber (3x4).

11. LEGAL IMPLICATION

The Chief Executive, as Accountable Officer, has responsibility for maintaining a sound system of Internal Control and reviewing the effectiveness of the system within their organisation culminating in the preparation of an annual Governance Statement.

12. INFORMATION TECHNOLOGY IMPLICATIONS

There are no IT implications associated with this paper.

13. HEALTH & SAFETY IMPLICATIONS

There are no Health and Safety Implications associated with this paper.

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no HAI issues associated with this paper.

15. DELEGATION LEVEL

Ms Lesley McLay is Chief Executive and Accountable Officer.

Ms Margaret Dunning, Board Secretary, is the Executive Lead for Strategic Risk Management Systems.

Mrs Hilary Walker, Risk Manager, is responsible for the implementation of risk management plans and follow up process.

16. TIMETABLE FOR IMPLEMENTATION

The Lead Officer for Strategic Risks is the Board Secretary with support from Mrs Hilary Walker, Risk Manager. Work in relation to the changes and improvements outlined within this paper, are in progress.

Ms M Dunning
Board Secretary

Ms L McLay
Chief Executive

Mrs H Walker
Risk Manager

October 2016

NHS TAYSIDE RISK RATINGS – STRATEGIC RISK PROFILE

Appendix A

	Datix Ref	Risk Title	Lead Director/ Risk Owner	Inherent Risk Exposure	1 April 2013-31 March 2014			1 April 2014 – 31 March 2015		1 April 2015 – 31 March 2016			1 April 2016 – 31 March 2017		Planned Risk Exposure	Current Risk Trend
					April 2013	Oct 2013	Feb 2014	April 2014	Dec 2014	April 2015	Oct 2015	Feb 2016	June 2016	Oct 2016		
Tayside NHS Board: Chair – John Connell/Lead Officer – Lesley McLay																
1	239	Health and Social Care Integration	Director of Primary and Community Services	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	20 (4x5) Very High	20 (4x5) Very High	12 (3x4) High	8 (2x4) Medium	8 (2x4) Medium	12 (3x4) High	Risk reviewed/ archived 2/9/16	6 (3x2) Medium	
2	26	Waiting Times and RTT Targets	Chief Operating Officer	25 (5x5) Very High	20 (5x4) Very High (LDP)	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	25 (5x5) Very High	15 (5x3) High	15 (5x3) High	15 (5x3) High	15 (5x3) High	15 (5x3) High	15 (5x3) High	→
3	14	Infection Management	Medical and Nurse Directors	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (4x5) Very High	20 (4x5) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	16 (4x4) High	→
4	201	Health Equity	Director of Public Health	25 (5x5) Very High	-	-	-	-	16 (4x4) High	16 (4x4) High	16 (4x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	→
5	313	Capacity and Flow (Winter Plan)	Chief Operating Officer	25 (5x5) Very High	-	-	-	-	-	-	-	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	→
6	312	NHS Tayside Estate Infrastructure Condition	Chief Operating Officer	20 (5x4) Very High	-	-	-	-	-	-	-	20 (5x4) Very High	16 (4x4) High	16 (4x4) High	6 (2x3) Medium	→
7	353	Sustainable Primary Care Services	Chief Officer, Angus IJB	20 (5x4) Very High	-	-	-	-	-	-	-	12 (4x3) High	12 (4x3) High	12 (4x3) High	9 (3x3) Medium	→
Finance and Resources Committee: Chair – Doug Cross/Lead Officer – Lindsay Bedford																
8	36	Strategic Financial Plan 2015/16 – 2019/20	Director of Finance	25 (5x5) Very High	12 (3x4) High	12 (3x4) High	12 (3x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	20 (4x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	→
9	37	Impact of Reduction in Capital Resources	Director of Finance	20 (5x4) Very High	16 (4x4) High	16 (4x4) High	16 (4x4) High	12 (3x4) High	12 (3x4) High	16 (4x4) High	16 (4x4) High	20 (5x4) Very High	20 (5x4) Very High	16 (4x4) High	20 (5x4) Very High	↓
10	38	Information Governance Risk	Board Secretary	25 (5x5) Very High	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	12 (4x3) High	12 (4x3) High	12 (4x3) High	12 (4x3) High	12 (4x3) High	9 (3x3) Medium	→

	Datix Ref	Risk Title	Lead Director/ Risk Owner	Inherent Risk Exposure	1 April 2013-31 March 2014			1 April 2014-31 March 2015		1 April 2015 – 31 March 2016			1 April 2016 – 31 March 2017		Planned Risk Exposure	Current Risk Trend
					April 2013	Oct 2013	Feb 2014	April 2014	Dec 2014	April 2015	Oct 2015	Feb 2016	June 2016	Oct 2016		
11	415	Implementation of Trackcare	Director of e-Health	20 (5x4) Very High	-	-	-	-	-	-	-	-	-	12 (4x3) High	8 (4x2) Medium	-
Staff Governance Committee: Chair – Munwar Hussain /Lead Officer – George Doherty																
12	95	Medical Workforce	Director of Human Resources	25 (5x5) Very High	9 (3x3) Medium	9 (3x3) Medium	12 (3x4) High	12 (3x4) High	12 (3x4) High	16 (4x4) High	16 (4x4) High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	9 (3x3) Medium	→
13	58	Workforce Optimisation	Director of Human Resources	20 (4x5) Very High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	16 (4x4) High	9 (3x3) Medium	↑
14	280	Nursing and Midwifery Workforce	Nurse Director	20 (5x4) Very High	-	-	-	-	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	16 (4x4) High	→
Clinical and Care Governance Committee: Chair – Alison Rogers /Lead Officer – Gillian Costello/Andrew Russell																
15	16	Clinical Governance	Medical and Nurse Directors	25 (5x5) Very High	16 (4x4) High	20 (4x5) Very High	20 (4x5) Very High	20 (4x5) Very High	20 (4x5) Very High	15 (3x5) High	15 (3x5) High	15 (3x5) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	→
16	121	Person Centeredness	Medical and Nurse Directors	20 (4x5) Very High	-	12 (4x3) High	12 (4x3) High	12 (4x3) High	8 (4x2) Medium	16 (4x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	9 (3x3) Medium	→
17	22	Health Protection of Children and Young People	Nurse Director	25 (5x5) Very High	12 (3x4) High	12 (3x4) High	16 (4x4) High (Vulnerable People)	12 (3x4) High	12 (3x4) High	20 (5x4) Very High	20 (5x4) Very High	16 (4x4) High	16 (4x4) High	16 (4x4) High	9 (3x3) Medium	→
18	15	Delivering Care for Older People	Medical and Nurse Directors	16 (4x4) High	-	-	-	9 (3x3) Medium	9 (3x3) Medium	12 (4x3) High	12 (4x3) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	9 (3x3) Medium	→
19	395	Mental Health Services – Sustainability of Safe and Effective Services	Director of Mental Health Services	20 (4x5) Very High	-	-	-	20 (4x5) Very High	12 (3x4) High	12 (3x4) High	12 (3x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	12 (4x3) High	→

	Datix Ref	Risk Title	Lead Director/ Risk Owner	Inherent Risk Exposure	1 April 2013-31 March 2014			1 April 2014-31 March 2015		1 April 2015 – 31 March 2016			1 April 2016 – 31 March 2017		Planned Risk Exposure	Current Risk Trend
					April 2013	Oct 2013	Feb 2014	April 2014	Dec 2014	April 2015	Oct 2015	Feb 2016	June 2016	Oct 2016		
20	144	Maternity Services	Medical and Nurse Directors	20 (4x5) Very High	-	-	-	20 (4x5) Very High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	→
21	302	PRI/Patient Flow	Medical Director Operational Unit	25 (5x5) Very High	-	-	-	-	-	-	20 (5x4) Very High	20 (5x4) Very High	16 (4x4) High	16 (4x4) High	12 (3x4) High	→
22	414	Managed/2c Practices	Medical Director	25 (5x5) Very High	-	-	-	-	-	-	-	-	-	20 (5x4) Very High	12 (3x4) High	-

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	26
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Deliver on the priority areas in our clinical strategy including achieving HEAT targets

Risk Ownership

Directorate/H&SCP	Directorate of Acute Services
Clin. Group/Dept	Business Unit
Title	Waiting Times and RTT Targets
Description	Failure to deliver on the key national targets for waiting times and RTT targets
Owner The Owner of the risk is the person who has overall corporate responsibility	Wiggin, Lorna - Director of Acute Services
Manager The Manager of the risk is the person who manages it on the owner's behalf	Lowry, Sarah - Business Unit Team Manager
Last updated	Sarah Lowry 13/10/2016 13:51:12

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	25
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Moderate (Category 2)
	Likelihood (current):	Almost certain - could occur frequently
	Rating (current):	15
	Risk level (current):	HIGH

Rationale for Current Score	TTG and Outpatient performance has deteriorated during the start of 2016/17, whilst there have been some improvements in Diagnostic performance. Cancer waiting times, remain below standard. Sustainability plans for 2016/17 have been developed and identify the requirement for significant funding which is being provided either nationally or locally non-recurrently. The plans funded to date indicate that performance will continue to improve for Diagnostics, however with significant risks within Urology in particularly, performance for TTG and Outpatients will not improve overall and achievement of the targets will not be achieved. In addition, a delay on decisions regarding the providers and capacity that it is possible to outsource is preventing the agreement of some service plans. Regular meetings continue to be held with SG Access Department to monitor progress and fortnightly conference calls are held with the SG Cancer Support Team to report on progress with CWT performance.

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Moderate (Category 2)
	Likelihood (Target):	Almost certain - could occur frequently
	Rating (Target):	15
	Risk level (Target):	HIGH
Rationale for Planned Score	This risk has matured into an issue, consequently the planned score and current score have been equalised The ongoing challenge is to find funding to manage the queues that have developed.	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
A 3 year 'see and treat' contract, commencing April 2016, has been agreed with Golden Jubliee National Hospital (GJNH) for foot and ankle procedures
Independent review of waiting times booking process and practices to commence in June 2016 for up to 6 weeks
New waiting times governance structure agreed with implementation of weekly meetings commencing 3rd June 2016
Independent review of booking practices and procedures has been commissioned to take place over a 4-6 week period commencing at the start of June 2016
Service Planning meetings scheduled for October and November to review 2016/17 performance and plan ahead for 2017/18
Additional activity for TTG, Outpatients and Diagnostics to be delivered between April 2016 - March 2017
The Business Unit have secured 3 months analyst support from ISD to work on capacity and demand modelling for specialities with existing capacity challenges. This work will support the establishment of sustainability plans for 2016/17.
Key Waiting Time measures monitored by Waiting Times Accountability Group and reported by Access Directorate to SMT; Directors; Board and SG:1. Cancer 31 and 62 day waits. 2. Treatment Time Guarantee (TTG) 3. 12 week Stage Of Treatment (SOT) 4. 18 week Referral To Treatment (RTT)5. Diagnostic Monthly Management Information (DMMI)
Assurance of compliance to Waiting Times Access Policy by Access Directorate through: 1. Process Assurance Bundle 2. Waiting Times Control Matrix 3. Waiting Times Assurance Monthly Return 4. TTG System Audit
Monthly Directorate Waiting Times reports to SMT and monthly Directorate performance Reviews.
Cancer Waiting Times Improvement plan reported to Cancer Overview Group Monthly

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
	1. Waiting Times papers produced monthly following review of assurance items 1-4 above by Waiting Times Accountability Group. The WTAG include all of the performance standards identified in the underpinning service level risks in table below.
	2. The WT papers are reported to SMT and Directors in following months. Directors produce board report based on these papers.
	3. Waiting Times Report Board assurance dashboard with exceptions reported from 1 above.
	4. CWT are reviewed by every cancer service on a monthly basis. The full report is reviewed by Waiting Times Accountability Group on a monthly basis and submitted to Cancer Overview Group every two months.

Gaps in Assurances
What additional assurances should we seek?

Source	Value
	None Identified

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance	Performance measured against Waiting Times standards is consistently failing. This is due to the organisations lack of available resources to deliver these standards. Following improvements in TTG performance up to the end of March 2016, performance has deteriorated with 910 patients waiting over 12 weeks as at the end of August 2016. This performance was 23 greater than the trajectory for August. Diagnostic performance improved over recent months with 141 patients waiting over 6 weeks as at the end of August 2016, this placed us 73 patients ahead of trajectory. Following improvements in Outpatient performance up to the end of March 2016, performance has deteriorated with 5143 patients waiting over 12 weeks as at the end of August 2016.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
37	Philip Wilde	Philip Wilde	Risk Register	New Risk Review		22/11/2012	15/08/2013	
500	Alan Pattinson		Risk Register	One month risk review	Review again in one month	14/09/2013	14/05/2015	Medium Priority
2355	Alan Pattinson		Risk Register	One month risk review		13/06/2015	14/05/2015	
2853	Alan Pattinson	LWILSO	Risk Register	Waiting Times Assurance Audit	Waiting Times Assurance Audit reviewed at Waiting Times Accountability Group and reported to Senior Management Team	30/09/2015	23/09/2015	High Priority
2855	Alan Pattinson	LWILSO	Risk Register	Actions to address breaches	Actions to address the breaches are part of the ongoing discussion with Scottish Government.	30/09/2015	23/09/2015	High Priority
2854	Alan Pattinson	LWILSO	Risk Register	CWT Reporting	Implemented new CWT reporting	27/11/2015	23/09/2015	High Priority
3004	Alan Pattinson		Risk Register	Three month risk review	tba	19/01/2016	22/01/2016	High Priority
2852	Lorna Wiggin	LWILSO	Risk Register	Waiting Time Standards	Waiting Times standards have been reached as	31/03/2016	09/10/2015	High Priority

					extended waits have already occurred. Planning for trajectory back to compliance being discussed with Scottish Government.			
3421	Sarah Lowry		Risk Register	One month risk review	NHS Tayside have undertaken an initial review of service capacity and anticipated demand for 2016-17 in order to identify anticipated recurring capacity shortfalls. This work aligns to the aims of the national 'Getting Ahead – sustainable whole systems management for elective services' (DL (2016) 2) programme which focuses on developing detailed risk analysis to assess activity requirements to ensure the best possible performance against elective waiting time targets in 2016/17. This work has been undertaken with support from an analyst from Information Services Division (ISD) Scotland and regular meetings with the Access Support Team at Scottish Government which has ensured scrutiny and assurance regarding the approach being taken. It should also be noted that any relevant learning from the recent CAMHS internal audit was applied accordingly. This work has resulted in the development of activity and investment plans to support improvements in the current waiting times against three core national standards, namely; Treatment Time Guarantee, New Outpatients and 8 Key Diagnostics. The plans include investment to reduce existing queues as well as supporting recurring gaps in capacity that have been identified. Local options for delivering the required levels of activity have been the key focus; however where local capacity is not available to meet the anticipated demand, external options have been sought (i.e. outsourcing to the independent sector).	30/04/2016	13/10/2016	High Priority

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

						being taken. It should also be noted that any relevant learning from the recent CAMHS internal audit was applied accordingly. This work has resulted in the development of activity and investment plans to support improvements in the current waiting times against three core national standards, namely; Treatment Time Guarantee, New Outpatients and 8 Key Diagnostics. The plans include investment to reduce existing queues as well as supporting recurring gaps in capacity that have been identified. Local options for delivering the required levels of activity have been the key focus; however where local capacity is not available to meet the anticipated demand, external options have been sought (i.e. outsourcing to the independent sector).		

One month risk review

				Register	review	again in one month		

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2355	Alan Pattinson		Risk Register	One month risk review		13/06/2015	14/05/2015		Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3004	Alan Pattinson		Risk Register	Three month risk review	tba	19/01/2016	22/01/2016	High Priority	Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	14
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Provide care in a safe, clean environment

Risk Ownership

Directorate/H&SCP	Access Directorate
Clin. Group/Dept	Infection Control
Title	INFECTION MANAGEMENT
Description	•Not all HAI HEAT targets within acute and community settings may be met. •NHST cannot provide assurance that there will be consistent compliance with all national and local requirements at all times. •Outbreaks of infection (by nature sometimes unpredictable) and incidents which impact on the ability to provide a safe, clean environment could affect patient and staff safety and organisational reputation. • There is always a risk that new or evolving infection risks will be a threat, e.g. CPE (highly antibiotic resistant bacteria & a national priority for control) or novel viruses • Adverse reports from external agencies e.g. HSE, HPS, HIS, etc. will have a negative reputational impact
Owner The Owner of the risk is the person who has overall corporate responsibility	Costello, Gillian - Nurse Director
Manager The Manager of the risk is the person who manages it on the owner's behalf	Weir, Mrs Dawn - General Manager Infection Control, Ninewells
Last updated	Mrs Dawn Weir 08/08/2016 15:57:20

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Major (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	20
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Almost certain - could occur frequently
	Rating (current):	20
	Risk level (current):	VHIGH
Rationale for Current Score	Failure in this area will impact on patient care and service delivery and is therefore critical.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Major (Category 1)
	Likelihood (Target):	Likely - could occur several times
	Rating (Target):	16
	Risk level (Target):	HIGH
Rationale for Planned Score	Recognising the impact of failures could have a major impact on patient care and service delivery.The aim is to reduce the likelihood of this occurring by promoting and supporting compliance with statutory and mandatory requirements	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Process in place to adopt any new polices or guidance issued by or on behalf of the Scottish Government.
Adherence to local and national policies and protocols by all staff
Lead Doctor Infection Control & Management reports to Directors Meeting quarterly.
Surveillance, alert organism and audit systems
Timely and appropriate data distribution for use by clinical areas with information readily accessible via Staffnet.
NHST HAI Education Strategy is available which provides up-to-date links to education resources including Learnpro modules compiled by NHS Education for Scotland (NES), Cleanliness Champion programme (NES) and a local programme of education. Annual HAI update requirement for staff education

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	HAI Report to every NHS Tayside Board meeting includes HEAT target progress, outbreaks and incidents, progress against inspection improvement action plans
INT	Involvement of Lead Doctor/General Manager Infection Control & Management in Performance Review meetings.
INT	Infection Control Annual Report incorporating Antimicrobial Annual Report
INT	Series of meetings both strategic and operational within the organisation with Lead Doctor reporting to Directors Meeting on a quarterly basis.
INT	Proactive management e.g. surveillance and alert systems
INT	National HEAT reporting.
EXT	Laboratory data submitted via ECOSS to HPS
INT	Microbiology laboratory in line with National testing protocols and CPA accredited
INT	Key personnel in place (Infection Control Doctor, Legionella and Water Responsible person and Antimicrobial Lead)
IA	Internal audit reports
EXT	HIS NHS Tayside HAI Self Assessment

EXT	External HIS Inspections
EXT	HSE Visits to Tayside
EXT	HPS visits to Tayside

Gaps in Assurances
What additional assurances should we seek?

Source	Value
INT	Property Services progress with Statutory Compliance Audit Risk Tool (SCART) as it applies to Infection Control.

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance

A robust surveillance programme and a proactive work plan delivered by the Infection Control Team will enable NHST to be in a position to identify issues early with established routes to escalate as required.
Challenges are competing priorities and demands for service delivery with mitigation of risk being dependent on staff adherence to policy and consistent application of good practice.

Vale of Leven Report published November 2014. Health Boards completed SG pro-forma detailing current position to allow SG to summarise position across Scotland. Updated position provided June 2015. Mapping exercise undertaken against NHS Grampian HIS & Vale of Leven Reports. To ensure that NHST continues to take cognisance of recommendations GM IC&M co-ordinates overall NHST update position 6 monthly (June & December).

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
26	Philip Wilde	Philip Wilde	Risk Register	New Risk Review		31/10/2012	15/08/2013	
496	GMARR		Risk Register	One month risk review		14/09/2013	13/06/2014	
724	MMCGUI	MMCGUI	Risk Register	Six month risk review	six month review	17/05/2014	16/05/2014	Medium Priority
1761	Mrs Dawn Weir		Risk Register	Six month risk review		11/11/2014	04/12/2014	
1762	Mrs Dawn Weir		Risk Register	Six month risk review	Review carried out	19/05/2015	04/12/2014	Medium Priority
2352	Mrs Dawn Weir		Risk Register	Six month risk review		08/11/2015	06/11/2015	
2858	Mrs Dawn Weir	LWILSO	Risk Register	Infection Control Annual Work Plan	Dynamic IC Annual Work Plan which is approved and reported to NHST Board	31/03/2016	24/03/2016	High Priority
2859	Mrs Dawn Weir	LWILSO	Risk Register	Action Plans for Programme of Audits	Programme of audits at ward and department level are accompanied by action plans.	31/03/2016	24/03/2016	High Priority

2860	Mrs Dawn Weir	LWILSO	Risk Register	Infection Control - codes of practice	NHST strives to comply with statutory and mandatory requirements and codes of practice in all areas of Infection Control.	31/03/2016	24/03/2016	High Priority
2861	Mrs Dawn Weir	LWILSO	Risk Register	HEI HAI Improvement Action Plans	Progress against HIS NHS Tayside HEI HAI Improvement Action Plans following publication of each inspection are included within HAI Board report.	31/03/2016	24/03/2016	High Priority
3049	Mrs Dawn Weir		Risk Register	Six month risk review		30/04/2016	03/05/2016	
3379	Mrs Dawn Weir		Risk Register	Six month risk review		03/08/2016	08/08/2016	
3986	Mrs Dawn Weir		Risk Register	Six month risk review		23/01/2017		

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	26	Philip Wilde	Philip Wilde	Risk Register	New Risk Review		31/10/2012	15/08/2013		Y

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	496	GMARR		Risk Register	One month risk review		14/09/2013	13/06/2014		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	724	MMCGUI	MMCGUI	Risk Register	Six month risk review	six month review	17/05/2014	16/05/2014	Medium Priority	Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1761	Mrs Dawn Weir		Risk Register	Six month risk review		11/11/2014	04/12/2014		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1762	Mrs Dawn Weir		Risk Register	Six month risk review	Review carried out	19/05/2015	04/12/2014	Medium Priority	Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2352	Mrs Dawn Weir		Risk Register	Six month risk review		08/11/2015	06/11/2015		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3049	Mrs Dawn Weir		Risk Register	Six month risk review		30/04/2016	03/05/2016		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3379	Mrs Dawn Weir		Risk Register	Six month risk review		03/08/2016	08/08/2016		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3986	Mrs Dawn Weir		Risk Register	Six month risk review		23/01/2017			Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	201
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Optimise the health and quality of lives of people living in Tayside and reduce inequalities

Risk Ownership

Directorate/H&SCP	Public Health
Clin. Group/Dept	Public Health Kings Cross
Title	Health Equity
Description	As a result of NHS Tayside and its Partners failing to prioritise health equity issues in all decision making there is a risk that we will fail to reduce the health equity gap.
Owner The Owner of the risk is the person who has overall corporate responsibility	Walker, Dr Drew - Director of Public Health
Manager The Manager of the risk is the person who manages it on the owner's behalf	Scott, Hazel - General Manager Public Health
Last updated	Hazel Scott 13/06/2016 14:23:20

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	25
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Possible - may occur occasionally
	Rating (current):	12
	Risk level (current):	HIGH
Rationale for Current Score	Failure in this area would have an impact on delivery of objectives and is therefore scored highly as we are also dependent upon the actions of our partners. The rationale for planned score has reduced in terms of likelihood from likely to possible as we have now obtained full committment of partners to integrate health equity within their strategic and commissioning plans.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Major (Category 1)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	12
	Risk level (Target):	HIGH

Rationale for Planned Score	While the impact of failures could have a major impact, the aim is to reduce the likelihood of this occurring. However, the level of engagement and activity within the organisation and with partners needs to be increased to achieve this. This has progressed positively since the establishment of IJB's. Health equity has become a central element within IJB strategic and commissioning plans.

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Health Equity Strategy 2010
Community Planning Partners have Health Equity as an objective
Community Planning Partner meeting x3
Director of Public Health is NHST Executive Lead for Community Planning and Health Equity
Health Equity focused programmes across Tayside working towards closing the gap
Health Equity Scottish Government priority with expectation on Boards that they will work towards Health Equity
Audit carried out 2013 by Director of Public Health to assess implemetation of Health Equity Strategy.
Internal Audit Report 1715 & populated action plan to Audit Committee for agreement 3/9/15
Inaugural meeting of Health Equity Governance Board - 1 October 2015
A further Meeting of the Health Equity Governance Board - 23rd January and 18 April 2016 - Process for reporting progress from each of the partners agreed
A series of meetings with each of the senior planning officer within the IJBs and health partner organisations has resulted in their strategic and commissioning plans including HE objectives - consultation process concluded. Strategic Plans and Commissioning Plans being presented to IJB Boards April 2016
Integrated Joint Boards now agreed and signed off strategic and commissioning plans. Each plan includes specific initiatives and objectives to address health inequalities
IJB's in process of developing Health Equity Strategies. Consultation in progress.

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Results from 2013 Audit reported to NHS Tayside Directors Meeting July 2014.
INT	Report on audit of implementation of Health Equity Strategy (December 2015).
INT	Monitor Health Equity KPIs in directorate performance review framework.
IA	Internal Audit Report T1715
IA	Internal Audit Report T1715 and Action Plan populated by Public Health Directorate to Audit Committee 3/9/15
IA	Internal Audit Report T1715 and Action Plan populated by Public Health Directorate to Audit Committee 27 January 2016
IA	Internal Audit Report T1715 and Action Plan populated by Public Health Directorate to Audit Committee 24 March 2016
IA	Internal Audit Report T1715 and Action Plan populated by Public Health Directorate to Audit Committee 22 April 2016
INT	Integrated Joint Boards agreed Strategic and Commissioning Plans (inc Health Equity) April 2016

Gaps in Assurances
What additional assurances should we seek?

Source	Value
	None Identified

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance

Statistics demonstrate a gap in life expectancy and health experience between most affluent and least affluent areas and individuals in Tayside.There are significant challenges in supporting NHS Tayside and partners to implement the recommendations of the health equity strategy. This has significant consequences for demand on acute services and for achieving 2020 vision objectives.

Enhanced performance reporting, which provides explicit evidence of achievement, would be of benefit in the level of resource to be devoted to Health Equity, particularly in times of scarce resource and competing priorities. Greater attention to the BAF may also be of assistance, especially as the Board's approach to risk appetite evolves.

A national review of Public Health policy began in December 2014, and is ongoing, with the aim of incorporating health inequalities into all Scottish public health policy. Any conclusions will be reflected in the Health Equity BAF and the Health Equity Strategy.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
1534	Dr Drew Walker		Risk Register	Three month risk review	Work is continuing to raise awareness with the senior management team around implementation. An audit has been undertaken and results are being analysed.	18/12/2014	27/04/2015	Medium Priority
2287	Hazel Scott		Risk Register	Three month risk review	NA	26/07/2015	12/08/2015	Medium Priority
2875	Dr Drew Walker	LWILSO	Risk Register	Report on Health Equity	Report to Tayside NHS Board on Health Equity as part of Department of Public Health Annual Report	31/08/2015	28/09/2015	High Priority
2876	Dr Drew Walker	LWILSO	Risk Register	Audit - implmentation of Health Equity Strategy	Repeat Audit of implementation of Health Equity Strategy.	31/12/2015	28/09/2015	High Priority
2877	Dr Drew Walker	LWILSO	Risk Register	Health Equity Strategy	NHS Tayside and Partners need to more fully implement Health Equity Strategy	31/03/2016	01/04/2016	High Priority
2878	Dr Drew Walker	LWILSO	Risk Register	Additional approaches to Health Equity Strategy	NHS Tayside Directors to consider additional approaches to implementing Health Equity Strategy. This will then further develop additional mitigating actions.	31/03/2016	01/04/2016	High Priority
2879	Dr Drew Walker	LWILSO	Risk Register	Health Equity KPI's	Health Equity KPIs should be included within the performance review framework for directorates as well as the Board Performance report	31/03/2016	01/04/2016	High Priority
2880	Dr Drew Walker	LWILSO	Risk	Locality Single	All three locality Single	31/03/2016	01/04/2016	High

			Register	Outcome Agreements	Outcome Agreements highlight tackling health inequalities as a priority. Performance indicators and key milestones identified in the Single Outcome Agreements should be reflected in the Health Equity Strategy.			Priority
2881	Dr Drew Walker	LWILSO	Risk Register	Standing Agenda Item - Joint Boards	Health Equity/Health Inequalities should be a standing agenda item for all Joint Boards.	31/03/2016	01/04/2016	High Priority
3345	Hazel Scott		Risk Register	Three month risk review	risk reviewed and updated	21/04/2016	27/04/2016	Medium Priority
2882	Margaret Dunning	LWILSO	Risk Register	Health Equity Corporate Risk	Every paper relating to Health Equity should specifically highlight how it is contributing towards the Health Equity corporate risk in order to ensure that papers are given due consideration and are taken at the Board as appropriate.	29/04/2016	29/04/2016	High Priority

Risk Reviews

On completing a risk review, remember to set a new risk review date

Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1534	Dr Drew Walker		Risk Register	Three month risk review	Work is continuing to raise awareness with the senior management team around implementation. An audit has been undertaken and results are being analysed.	18/12/2014	27/04/2015	Medium Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2287	Hazel Scott		Risk Register	Three month risk review	NA	26/07/2015	12/08/2015	Medium Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3345	Hazel Scott		Risk Register	Three month risk review	risk reviewed and updated	21/04/2016	27/04/2016	Medium Priority	Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	313
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Agencies working together and with communities to improve services and health outcomes Improve patient experience of our services Improve quality of care in all health settings

Risk Ownership

Directorate/H&SCP	Directorate of Acute Services
Clin. Group/Dept	Resilience Planning
Title	Winter Plan
Description	There is a risk that NHS Tayside is unable to recruit additional workforce to support the acute services and local authority plans as detailed within the NHS Tayside Winter Plan 2015/16 which may result in: - unsatisfactory patient experience - an increase in delayed discharges - patients being boarded - closure of neighbouring health boards and vice versa - elective cancellations leading to damage to organisational reputation.
Owner The Owner of the risk is the person who has overall corporate responsibility	McLay, Lesley - Chief Executive
Manager The Manager of the risk is the person who manages it on the owner's behalf	Wiggin, Lorna - Director of Acute Services
Last updated	Lisa Dempster 26/01/2016 15:03:01

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	25
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Almost certain - could occur frequently
	Rating (current):	20
	Risk level (current):	VHIGH

Rationale for Current Score	Failure to ensure the right workforce in the right place will impact upon timely access to patients securing a bed within the correct specialty and will result in an inability to discharge patients home across 7 days.

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Major (Category 1)
	Likelihood (Target):	Almost certain - could occur frequently
	Rating (Target):	20
	Risk level (Target):	VHIGH
Rationale for Planned Score	NHS Tayside and its partners are already aware of the steps that require to be taken to attempt to remedy the situation and are proactively managing this. As such, there is no further action to be taken and the planned risk exposure remains 5x4 - Red Risk.	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Advertisements out for both acute and support services. CT agreed.
PDD - proactive discharge scheme.
Implementation of frailty unit.
Rotas developed and in place for over winter and festive periods.
Additional ambulance transportation agreed.
Seasonal flu vaccination programme in place for staff.
Additional support secured for front door/main concourse Ninewells Hospital
New tests of bleep holder in AMU (GP)
Additional consultant being interviewed for PRI
General Manager appointed for PRI
Delayed discharge plans developed and in place in each IJB
Duty Manager and Executive on Call Rotas already in place

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Real time data for patient management
INT	Monitoring and escalation plan in place with appropriate whole system representation (Local Authority/Social Care/Acute Services)
INT	Key Performance Indicators included in Board Paper and monitored weekly
INT	Operational Group who are responsible for ensuring implementation of Winter Plan through KPIs and investment

INT	Strategic Group to whom issues can be escalated

Gaps in Assurances
What additional assurances should we seek?

No values

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance

Delayed Discharges
Boarding
Elective cancellations
Sickness absence as as result of norovirus
Ward Closures

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
3024	Lorna Wiggin		Risk Register	One month risk review	Winter plan and Integrated Joint Board Delayed discharge plans agreed at NHS Tayside Board meeting 30th November 2015.	27/11/2015	08/12/2015	Medium Priority
3338	Lorna Wiggin	Hilary Walker	Risk Register	Winter Plan	Winter Plan agree with performance to be reviewed at each Board meeting	31/01/2016	01/12/2015	High Priority
3342	Lorna Wiggin		Risk Register	One month risk review	Unsceduled care plan agreed across Acute services and IJBs by NHS Tayside Board.	21/02/2016	01/04/2016	High Priority
3341	Carol Goodman	Hilary Walker	Risk Register	Red Cross	General Manager, Medicine Directorate to explore securing support during the transfer of patients into their homes (enhanced service)	31/03/2016		Medium Priority
3337	Andrew Russell	Hilary Walker	Risk Register	7 day clinical/manager rota	Consider introduction of 7 day clinical/managerial rotas	31/03/2016		Medium Priority
3336	Alan Cook	Hilary Walker	Risk Register	NW Safety Huddles	Consider implementation of safety huddles for Ninewells	01/07/2016	04/07/2016	Medium Priority
3335	Lorna Wiggin	Hilary Walker	Risk Register	OOH support	Consider revised models for OOH support for over festive period.	31/10/2016		High Priority

3339	Lorna Wiggin	Hilary Walker	Risk Register	Outsourcing of Elective Activity	Outsourcing of elective activity to build resilience in system	12/12/2016		Medium Priority
3340	Jennifer Mudie	Hilary Walker	Risk Register	International Recruitment	International recruitment	31/12/2016		Low Priority

Risk Reviews

On completing a risk review, remember to set a new risk review date

Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3024	Lorna Wiggin		Risk Register	One month risk review	Winter plan and Integrated Joint Board Delayed discharge plans agreed at NHS Tayside Board meeting 30th November 2015.	27/11/2015	08/12/2015	Medium Priority	Y

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3342	Lorna Wiggin		Risk Register	One month risk review	Unsceduled care plan agreed across Acute services and IJBs by NHS Tayside Board.	21/02/2016	01/04/2016	High Priority	Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	312
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Building capacity and capability to achieve sustainable change Deliver on the priority areas in our clinical strategy including achieving HEAT targets Improve quality of care in all health settings Provide care in a safe, clean environment

Risk Ownership

Directorate/H&SCP	Operations Directorate
Clin. Group/Dept	Estates
Title	NHS Tayside Estate infrastructure condition
Description	Failure to upgrade the existing infrastructure and improve the condition, capacity and resilience, considering the entire property portfolio of NHS Tayside will result in a lack of capacity and resilience therefore restricting future site expansion, non compliance with current technical standards and legislation, the inability to deliver the anticipated capital plan resulting in reputational loss and the ability to meet clinical demand.
Owner The Owner of the risk is the person who has overall corporate responsibility	Armstrong, Ken - Director of Operations
Manager The Manager of the risk is the person who manages it on the owner's behalf	Anderson, Mark - Head of Property NHST
Last updated	Philip Wilde 01/08/2016 15:23:50

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Major (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	20
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Likely - could occur several times
	Rating (current):	16
	Risk level (current):	HIGH
Rationale for Current Score	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being implemented. National media/adverse publicity. Organisational/personal financial loss (£>1m)	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Moderate (Category 2)
	Likelihood (Target):	Unlikely - not expected to happen but might
	Rating (Target):	6
	Risk level (Target):	MED
Rationale for Planned Score	Upgrade the existing Estates infrastructure and improve the condition, capacity and resilience of the site wide systems including sub mains and final circuits, medical gases, ventilation systems, clinical air changes, electrical systems both sub mains and final circuits. All enhanced through replacement of existing plant, modifications to physical layouts, provision of dual electrical supplies.	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Condition reflected with the Estates Asset Management System.
Reported to Scottish Government via Property Asset Management Strategy 2015/2020
Ongoing condition surveys across NHS Tayside estate including mechanical and electrical infrastrucuture
Regular pre planned maintenance of, for example, theatre plant 12 and 48 week
Targeted use of available estates capital investment monies to address infrastrucure backlog e.g fire, lifts, ventilation etc
Directorate Business Continuity Plans consider their actions in event of system failure
Contract arrangements for specific failures such as water and emergency supplies and each bedded site has site specific water contingency plans
Reactive maintenance through estates fault line 24 hour service and emergency on call service
Emergency generator back up contract within 12 hour period
Ongoing regular training to ensure trained estates workforce have the relevant mandatory training for critical plant

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Update reports to each meeting of Capital Scrutiny Group in relation to either project status or emerging demands
INT	Infrastructure Recommendation paper to Directors
INT	Infrastructure Recommendation paper to F&R Committee - 15 October 2015
INT	Infrastructure recommendation to Tayside NHS Board - 25 February 2016
INT	Demands into Captial Investment programme and property and assest management stragegy document
INT	Head of Property attends each meeting of Finance and Resources Committee

Gaps in Assurances
What additional assurances should we seek?

Source	Value
INT	To define and confirm the link between the NHS Tayside clinical strategy and the NHS Tayside Property and Asset Management Strategy
INT	Availability of time within theatre schedules to allow for 24 week maintenance programme
INT	Planned electrical maintenance cannot be achieved due to difficulties in "Shut downs" of power
	Availability of dedicated decant facilities across NHS Tayside for use during upgrades

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance

Regular reviews and maintenance of current position. In depth condition surveys to inform prioritisation. Ongoing capital investment informed via the Estates Asset Management system (EAMS).

In recent times there have been episodes of sudden electrical failure. More recently a failure of the SSE main incoming electrical supply highlighted the many areas which are not provided with emergency power and which are non compliant. Concerns raised in relation to the functionality of clinical rooms by Consultant Microbiologist/lead Infection control officer, Director of Acute Services and Risk Manager. Current risks are being managed and mitigated against failure at an operational level.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
3044	Mark Anderson		Risk Register	Three month risk review		28/01/2016	02/02/2016	
3023	Mark Anderson	Philip Wilde	Risk Register	Infrastructure investment	A commitment to regular and ongoing programme of investment to enhance the infrastructure provision of the estate including: New transformers New high voltage cabling New switch gear Dual supplies for resilience and compliance Rewiring of the entire site including sub mains and final circuits. Recognition of the need to consider WIDER infrastructure investment within all capital funded projects, committment to fund similar via EAMS.	30/04/2016	29/02/2016	High Priority
3372	Mark Anderson		Risk Register	Three month risk review		02/05/2016	29/02/2016	
3486	Mark Anderson		Risk Register	Six month risk review	IA in development and discussion with SG. Funding in place for anabling works in 16/17	27/08/2016	31/08/2016	High Priority
3696	Mark Anderson	Hilary Walker	Risk Register	24 week maintenance	Surgical Directorate to review downtime to allow for planned 24 week maintenance	30/09/2016		High Priority

					programme and programme to be developed.			
3694	Mark Anderson	Hilary Walker	Risk Register	Scottish Government Capital Investment Group	Final intention to seek funding via paper to Scottish Government Capital Investment Group	30/12/2016		Medium Priority
3695	Mark Anderson	Hilary Walker	Risk Register	Capital Investment Group	Further papers to be developed to capture individual infrastructure requirements to Capital Investment Group	30/12/2016		Medium Priority

Risk Reviews

On completing a risk review, remember to set a new risk review date

Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3044	Mark Anderson		Risk Register	Three month risk review		28/01/2016	02/02/2016		Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3372	Mark Anderson		Risk Register	Three month risk review		02/05/2016	29/02/2016		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3486	Mark Anderson		Risk Register	Six month risk review	IA in development and discussion with SG. Funding in place for anabling works in 16/17	27/08/2016	31/08/2016	High Priority	Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	353
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Agencies working together and with communities to improve services and health outcomes Deliver on the priority areas in our clinical strategy including achieving HEAT targets Improve quality of care in all health settings

Risk Ownership

Directorate/H&SCP	Directorate of Primary and Community Services
Clin. Group/Dept	Admin and Managerial Team
Title	Sustainable Primary Care Services
Description	Failure to maintain sustainable Primary Care Services both in and out of hours in each locality in Tayside will result in a failure to achieve the 20/20 Vision, the National Clinical Strategy and patients being unable to access Primary Care Services.
Owner The Owner of the risk is the person who has overall corporate responsibility	Irons, Vicky - HSCI Chief Officer Angus, St Margarets House, Forfar
Manager The Manager of the risk is the person who manages it on the owner's behalf	Galloway, Jillian - Clinical Services Manager, Prisoner HC, OOH and FMS
Last updated	Hilary Walker 22/09/2016 14:41:30

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Major (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	20
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Moderate (Category 2)
	Likelihood (current):	Likely - could occur several times
	Rating (current):	12
	Risk level (current):	HIGH
Rationale for Current Score	To be populated	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Moderate (Category 2)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	9
	Risk level (Target):	MED

Rationale for Planned Score To be populated

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Angus IJB hosts Primary Care Arrangements
Chief Officer, Angus IJB has Executive leadership for Primary Care
Associate Medical Directors meetings are attended by the Associate Medical Director – Primary Care
Board Advisory Leads / Clinical Advisors for each contractor stream in place
NHS Tayside Workforce Plan
Pharmacy Directorate oversees Locality and Community Pharmacy arrangements
Primary Care currently incorporated within each IJB
National contracts for the 4 independent contractor schemes
National contract monitoring and payment verification process undertaken by the National Service Scotland Practitioner Services. Quarterly meetings with NHS Tayside
Practice visiting process in place
NES GP Recrutiment Scheme (inlcudes Retainers; Returners and Overseas)
Primary Care Strategy
GP High Level Workforce Plan Outline

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Primary Care reporting to CQF and Clinical and Care Governance Committee - framework is in place and reporting through Clinical and Care Governance Groups R3 to R2 to R1 - Joint Porfessional Forum (Not fully in place in each partnership)
INT	Reporting through Executive Group since CHP arrangements dismantled.
INT	Payment verification and quality assurance reporting to Audit Committee - this includes quarterly reporting and annual reporting on General Medical Services update for the year and plans for process in coming year
INT	Reporting through Directors and SMT meetings by Chief Officer, Angus IJB
INT	Assurance from practice visits visits - reporting through Primary Care Risk Management Committee
INT	Practices in Difficulty monitoring and monthly written report to Board informs of closed lists/changes in boundaries. This is also circulated to Directors.
INT	Weekly meeting via teleconference of OOH/SAS/IJBs to discuss operational risks and staffing issues.
INT	Standing Agenda Item at GP Advisory Committee on quarterly basis
INT	Associate Mdical Director for Primary Care provides a verbal update on a monthly basis at GP Sub Committee which submits minutes to the Area Clinical Forum
INT	Monthly Report on all Primary Care Services to Angus IJB Executive Meeting (Chief Officers of Dundee and Perth also receive copies)

EXT	Internal Audit Report 2015 T16/15 - 20:20 Priorities - Primary Care
EXT	Each Independent Contractor is subject to Inspections by the Regulatory Bodies

Gaps in Assurances
What additional assurances should we seek?

Source	Value
INT	Establishment of Performance Review system specifically for Primary Care
INT	No reporting to Clinical Quality Forum for Prisoner Healthcare and Forensic Medicine

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance	While there are a number of the risk mitigating actions in progress, there continues to be a concern that there will be further failures in General Practice that will challenge the capacity and capbility of NHS Tayside to manage the impact effectively.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
3423	Michelle Watts	Bill Nicoll	Risk Register	Development of Primary Care strategic framework for presentation to Tayside NHS Board in February 2016.	The primary Care Strategy will set out how the primary care services will be developed and how the current issues and risks will be addressed	25/02/2016	11/03/2016	High Priority
3435	Michelle Watts		Risk Register	One month risk review	ongoing risks re retention and recruitment. 1 recent episode no GP cover, several "red" epsisodes where GP cover less than reccommended minimum. bids submitted to SG for funding to support new posts, job descriptions develped escalation plans almost complete, still require whole system sign off	19/03/2016	30/03/2016	High Priority
3440	Bill Nicoll	Hilary Walker	Risk Register	Independent Contractors	Formalise engagement with all independent contractors	31/03/2016	02/09/2016	Medium Priority
3441	Michelle Watts	Hilary Walker	Risk Register	Quality Visits	Progress new process for Quality visits (beyond QOF)	31/03/2016	01/04/2016	High Priority
3437	Bill Nicoll	Hilary Walker	Risk Register	Primary Care Services Department	Requirement to clearly articulate Primary Care Services Department advisory capacity role with IJBs and define this relationship	31/03/2016	02/09/2016	High Priority
3438	Michelle Watts	Hilary Walker	Risk Register	OOH Workforce Plan	Development of OOHs Workforce Plan	31/03/2016	11/04/2016	High Priority

3444	Michelle Watts	Hilary Walker	Risk Register	Communication	Communication – ensure stakeholders are aware of changing model of service delivery.	31/03/2016	14/09/2016	High Priority
3425	Vicky Irons	Bill Nicoll	Risk Register	Development of a Hosting Framework setting out responsibility for operational governance of primary care service delivery through the Integration Joint Boards. Framework to include governance, accountabilities, responsibilities and relationships. This	Primary Care operational governance hosted by Angus IJB	31/03/2016	06/01/2016	Medium Priority
3439	Michelle Watts	Hilary Walker	Risk Register	Business Continuity Plan	Development of Business Continuity Plan for Primary Care	29/04/2016	07/07/2016	High Priority
3442	Michelle Watts	Hilary Walker	Risk Register	Performance Review	Develop separate, dedicated Performance Review for Primary Care aspects.	29/07/2016	02/08/2016	High Priority
3424	Michelle Watts	Bill Nicoll	Risk Register	Development of a primary care work plan to inform objectives to achieve the 2020 vision for primary care. Work plan should include risk prioritisation.	This will be the implementation plan and workforce plan for primary care	31/08/2016	29/08/2016	Medium Priority
3951	Jillian Galloway	Hilary Walker	Risk Register	OOH BCP	Complete review of Business Continuity Plan for Out of Hours Service	31/08/2016	01/09/2016	High Priority
3952	Gail Smith	Hilary Walker	Risk Register	IJB Performance Review	Develop Performance Review Framework for each Integrated Joint Board	31/08/2016	07/09/2016	Medium Priority
3953	Gail Smith	Hilary Walker	Risk Register	Internal Audit Report	Review Action Plan for Internal Audit Report T16/15 Primary Care	31/08/2016	07/09/2016	Medium Priority
3954	Michelle Watts	Hilary Walker	Risk Register	Practice Visits	Finalise data set for Practice Visits	31/08/2016	29/08/2016	Medium Priority
3958	Michelle Watts	Hilary Walker	Risk Register	Vacant GP Posts	Recruit to all vacant GP posts	31/08/2016	29/08/2016	High Priority
3959	Michelle Watts	Hilary Walker	Risk Register	Development and Testing	Complete development and testing of Electronic Care Summary (ECS), New Models of Care and OOH	31/08/2016	29/08/2016	Medium Priority
3443	Michelle Watts	Hilary Walker	Risk Register	Qlikview Dashboards	Consideration of inclusion of Primary Care data in QlikView dashboard	14/09/2016	14/09/2016	High Priority
3957	Vicky Irons	Hilary Walker	Risk Register	IJB Audit Committee	Complete establishment of Angus IJB Audit Committee	30/09/2016	18/07/2016	Medium Priority
4032	Jillian Galloway	Hilary Walker	Risk Register	Business Continuity Plans	Business Continuity Plans to be developed for Forensic Medical	31/10/2016		Medium Priority

					Services (FMS) and Prisoner Healthcare (PHC)			
3956	Gail Smith	Hilary Walker	Risk Register	Risk Profile	Review Risk Profile for Angus Integrated Joint Board	31/10/2016		Medium Priority
3436	Vicky Irons	Hilary Walker	Risk Register	Primary Care Governance	Operational governance for Primary Care sits with Angus IJB but there is a requirement to look at overall governance for Primary Care within NHS Tayside structures of assurance	30/11/2016		Medium Priority
3955	Michelle Watts	Hilary Walker	Risk Register	Implementation Plan	Develop and Deliver Implementation Plan for Primary Care Strategic Framework	30/11/2016		Medium Priority
3950	Michelle Watts	Hilary Walker	Risk Register	GP Workforce Plan	Develop a detailed GP Workforce Plan	30/12/2016		High Priority

Risk Reviews

On completing a risk review, remember to set a new risk review date

Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3435	Michelle Watts		Risk Register	One month risk review	ongoing risks re retention and recruitment. 1 recent episode no GP cover, several "red" epsisodes where GP cover less than reccommended minimum. bids submitted to SG for funding to support new posts, job descriptions develped escalation plans almost complete, still require whole system sign off	19/03/2016	30/03/2016	High Priority	Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	36
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Making the best use of resources and achieving financial balance

Risk Ownership

Directorate/H&SCP	Finance Directorate
Clin. Group/Dept	Finance Department
Title	Strategic Financial Plan 2016/17-2020/21
Description	Failure to deliver the Strategic Financial Plan (SFP) would place the delivery of national and local plans in jeopardy and would create the risk of breaching statutory financial obligations of the Board
Owner The Owner of the risk is the person who has overall corporate responsibility	McLay, Lesley - Chief Executive
Manager The Manager of the risk is the person who manages it on the owner's behalf	Bedford, Lindsay - NOT VERIFIER - Head of Finance
Last updated	Hilary Walker 24/08/2016 11:57:19

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	25
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Extreme (Category 1)
	Likelihood (current):	Almost certain - could occur frequently
	Rating (current):	25
	Risk level (current):	VHIGH
Rationale for Current Score	NHS Tayside is a Board that has an operating service model that extends beyond its budgeted financial allocation in terms of site reconfiguration, employed workforce resources, operational and facility maintenance costs. Benchmarking data from a wide a variety of sources consistently identifies that, in comparison with specific Boards or in general across Scotland, our spend patterns are in excess of the level of resource we receive. Service redesign and transformation is being implemented to not only distribute existing spend commitments in line with our Strategic Transformation programme, but to reduce our level of spend recognising the Board's overiding priority remains the commitment to the provision of safe and effective clinical services for people in our care.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Extreme (Category 1)
	Likelihood (Target):	Almost certain - could occur frequently
	Rating (Target):	25
	Risk level (Target):	VHIGH
Rationale for Planned Score	The Board submitted an unbalanced Local Delivery Plan in May 2016 to Scottish Government. This reflected the position around delivery in year of the initiatives being pursued nationally involving all Boards and also the high risk nature of delivery of a number of the local Tansformation Programme workstreams in 2016/17. The risk of delivery reflects both timing and value of efficiencies deliverable. The Board enters 2016/17 with an outstanding sum due to Scottish Government of £20m The principles governing repayment of this sum are to be discusssed with Scottish Government. A range of cots pressures remain within the system.	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Strategic Financial Plan approved by F&R Committee and Special Board meeting on 10 March 2016
Draft Local Delivery Plan (Finance Templates) submitted to Scottish Government March 2016. Local Delivery Plan templates considered by NHS Tayside Board at its meeting of 26th May 2016 and submitted an unbalanced LDP to Scottish Government totalling £11.65m
Senior Management Team, Executive Directors, Tayside NHS Board and Standing Committess will monitor progress around the Strategic Financial Plan through provision of a combination or verbal and written reports provided by the Director of Finance with the intention of increased transparenacy and improved governance through earlier reporting of financial results.
Detailed operational budgets maintained with regular contact and dialogue between the finance team and relevant budget managers. A forecast outturn position is maintained and updated on a monthly basis reflecting delivery on efficiency savings plans and cost pressures arising. Performance reviews are held on a rolling programme basis.
Introduction of 7 strategic workstream programmes as a result of recognition of the need for change and requirement to approach identification and timely delivery of efificencies savings in a different way.
Regular Development Events with Board to proivde updates in relation to workstream programmes, clinical strategy and financial position
Regular dialogue with Scottish Government on a monthly basis by Chief Executive and Director of Finance
Engagement and Communication Plan development session led by Chief Executive to SMT; Clinical Leads; AMDs; HONs
Informing and discussing with the SLT and the APF and creating a more open dialogue on the actions required in the medium term to return NHS Tayside to a sustainable financially balanced position
Series of Valuaing your NHS Informaiton Sessisons and regular publications to cascade information to Patients, staff and the Public
A transformation executive group, chaired by the Strategic Change Director, will review the activities of the seven strategic workstreams on a weekly basis allowing for decision making and deployment of resources to address issues or risks without delay.
Benchmarking data (e.g. financial and workforce) from a wide veriety of sources (e.g. ISD) to consistently identifies comparisons with specific Boards (e.g. Grampian, Lothian) or in general across Scotland.
Transformation Board, Chaired by NHS Tayside Chairman, established to support the delivery of changes that will result in sustainable financial balance,imprvoing patient outcomes, quality and safety and cost effective service delivery

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Monthly reporting to Finance and Resources Committee on progress of both Revenue and Capital
INT	Monthly monitoring reports to Senior Management Team and Executive Directors
INT	Separate Capital and Revenue Risk Registers maintained and reported to each meeting of Finance and Resources Committee

EXT	Monthly returns to Scottish Government Health Department
EXT	External and Internal Audit arrangements in place
EXT	Agreement of Local Delivery Plan with Scottish Government Health Department
EXT	Ministerial Annual Review
EXT	Scottish Government Health Department taking active overview of current position. Chief Executive and Director of Finance in regular dialogue with Scottish Government Health Department

Gaps in Assurances
What additional assurances should we seek?

Source	Value
INT	2 Non Executive Board Members currently reviewing existing finance rpeorting arrangements in conjunction with Director of Finance.
INT	Consideration requires to be given to how to enhance existing control measures in relation to reducing spend and areviewing risk assessment crtieria that provides permissions to incur spend only when the relevant conditions have been met.

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance	Progress at Operational level reported to CHPs, Area Partnership Forum, Senior Management Team, Executive Directors and ultimately Finance & Resources Committee and Tayside NHS Board. There are 3 component elements that the board is exposed to presently. An overspend on its core revenue resource limit; an exposure in relation to previous year commitments for enhancements during leave and an outstnading financial brokerage from scottish government recieved in preious years expected to be £9.5m by March 2016.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
81	GMARR		Risk Register	Three month risk review	Risk has regularly been reviewed and updated in March 2103, September 2013 and March 2014	09/05/2013	13/06/2014	Medium Priority
1240	Lindsay Bedford	Lindsay Bedford	Risk Register	Three month risk review	further 3 month review	11/09/2014	29/04/2015	Medium Priority
2304	Lindsay Bedford	Lindsay Bedford	Risk Register	Three month risk review	further 3 month review	28/07/2015	20/08/2015	Medium Priority
2804	Lindsay Bedford	LWILSO	Risk Register	Performance/spend profiles	Identification of areas where performance/spend profiles can be benchmarked against peer organisations	30/09/2015	06/10/2015	High Priority
2805	Lindsay Bedford	LWILSO	Risk Register	Strategic programmes/workstreams	Development of Director led strategic programmes/workstreams that recognise the need to develop a balanced financial plan which not only generates options to reduce costs but frees up resource to start addressing the 2020 vision.	30/09/2015	06/10/2015	High Priority
2663	Lindsay Bedford	Lindsay Bedford	Risk Register	Three month risk review		18/11/2015	17/02/2016	

3422	Lindsay Bedford	Lindsay Bedford	Risk Register	One month risk review		18/03/2016		
3010	Lesley McLay	Hilary Walker	Risk Register	Transformation Board	Establish Transformation Board to ensure greater governance around financial management and return over 3-5 year period to a financially balanced position.	31/03/2016	01/12/2015	High Priority
2802	Lindsay Bedford	LWILSO	Risk Register	Delivery of Financial Plan	Continue with all existing arrangements until 31 March 2016 and implement addition mitigating actions where required.	31/03/2016	30/06/2015	High Priority
2803	Lindsay Bedford	LWILSO	Risk Register	Budget Scrutiny	Continue with Budget scrutiny at performance review meetings to further drive efficiency	31/03/2016	30/04/2015	High Priority

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3422	Lindsay Bedford	Lindsay Bedford	Risk Register	One month risk review		18/03/2016			Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	81	GMARR		Risk Register	Three month risk review	Risk has regularly been reviewed and updated in March 2103, September 2013 and March 2014	09/05/2013	13/06/2014	Medium Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1240	Lindsay Bedford	Lindsay Bedford	Risk Register	Three month risk review	further 3 month review	11/09/2014	29/04/2015	Medium Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2304	Lindsay Bedford	Lindsay Bedford	Risk Register	Three month risk review	further 3 month review	28/07/2015	20/08/2015	Medium Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2663	Lindsay Bedford	Lindsay Bedford	Risk Register	Three month risk review		18/11/2015	17/02/2016		Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	37
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Building capacity and capability to achieve sustainable change Making the best use of resources and achieving financial balance Provide care in a safe, clean environment

Risk Ownership

Directorate/H&SCP	Finance Directorate
Clin. Group/Dept	Finance Department
Title	Impact of reduction in Capital Resources
Description	Insufficiency of capital resources to deliver the Clinical Strategy and the Property Asset Management Strategy will lead to an inability to delivery safe and effective care in an approriate healthcare environment which is fit for purpose which will result in damage to organisational reputation.
Owner The Owner of the risk is the person who has overall corporate responsibility	McLay, Lesley - Chief Executive
Manager The Manager of the risk is the person who manages it on the owner's behalf	Bedford, Lindsay - NOT VERIFIER - Head of Finance
Last updated	Lindsay Bedford 10/08/2016 09:28:12

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Major (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	20
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Likely - could occur several times
	Rating (current):	16
	Risk level (current):	HIGH
Rationale for Current Score	Failure in this area would have an impact on the Board's ability to support the Clinical Strategy, the PAMS and the Strategic Financial Plan. In addition captial resoures have continued to be reduced over the last 3 financial years which has a deterimental impact on the delivery of capital projects.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Major (Category 1)
	Likelihood (Target):	Likely - could occur several times
	Rating (Target):	16
	Risk level (Target):	HIGH

Rationale for Planned Score	The lack of investment funding could have an impact on Infection Control, Carbon Reduction Heat Targets and ability to deliver on modern fit for purpose healthcare facilities. More recently the HUB Procurement route has highlighted delays in Capital procurement. Critically the ability to refresh Medical Equipment & IT could have an impact on services. In addition Scottish Governement have indicated that Boards should assume a flat line position with rgarding ro formula capital funding as we move forward.

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Risk prioritisation of spend, taking into account the PAMS and Clinical Strategy
Budgets and processes approved by Finance & Resources and Tayside NHS Board. Strategic Financial Plan approved by Scottish Government. LDP approved by Scottish Government
Regular dialogue with senior management of Scottish Government Health and Social Care Department Capital and Facilities to highlight issues and discuss potential solutions
Capital spend approved prior to commencement by Chief Exec and Director of Finance (acting together), Finance & Resources Committee, Board and Scottish Government Capital Investment Group on the recommendation of Capital Scrutiny Group in accordance with their relevant delegated authority limits.
Individual departments exercise budgetary control but regular meetings with finance colleagues to ensure governance and relevant spend.
Standing Financial Instructions and Code of Corporate Governance covers capital spend and procurement
Capital Scutiny Group monitors capital spend through 10 regular meetings throughout the financial year
Budgets set for individual projects within the cpaital plan
Monthly reporting of actual and forecast capital spend to Scottish Government Health Social Care Department through Financial Performacne Returns.
Capital report produced on a monthly basis and reported to Capital Scrutiny Group and Finance and Resoures Committee

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Capital Scrutiny Group minutes passed to Finance & Resources Committee. Capital Scrutiny Group Annual Report presented to Finance & Resources Committee
INT	Reports presented to Finance & Resources Committee
INT	Finance & Resources Committee minutes passed to Board
INT	Internal and External Audit reports presented to Audit Committee. Audit Follow Up protocol ensures action points

	are addressed.
EXT	Approval of Strategic Financial Plan by Scottish Government Health Social Care Department
EXT	Observance of capital resource limit set by Scottish Government Health Department
INT	Audit Scotland reviews reported to Audit Committee
EXT	Regular dialogue with Scottish Government colleagues around Capital position both locally and nationally

Gaps in Assurances
What additional assurances should we seek?

Source	Value
	None identified

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance	Scottish Government Health Social Care Department approved the 2015-2020 Strategic Financial Plan and LDP on 31 March 2015. Progress is monitored by the Capital Scrutiny Group. Potenial slippage is identified around the Capital Resource Limit in the early part of each year and projects that can be prioritised against the slippage are accelerated to prevent any year end under spend on the capital programme and a potential loss of funding to the Board. In addition to the Capital Resource Limit the Board has identified £2m of revenue funding to support the Capital Plan.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
1024	Lindsay Bedford	Lindsay Bedford	Risk Register	Six month risk review	-	24/09/2014	01/06/2015	Low Priority
2474	Lindsay Bedford	Lindsay Bedford	Risk Register	Six month risk review		28/11/2015	17/02/2016	
3426	Lindsay Bedford	Lindsay Bedford	Risk Register	One month risk review		18/03/2016		
2812	Lindsay Bedford	LWILSO	Risk Register	Capital Resource Limit	Regular year end forecasting and any corrective action will be taken to ensure that the Capital Resource Limit is met.	31/03/2016		High Priority
2813	Lindsay Bedford	LWILSO	Risk Register	Strategic Financial Plan	Plan has a level of over committment to allow for slippage that takes place during the year through delays in projects.	31/03/2016		High Priority
2814	Lindsay Bedford	LWILSO	Risk Register	Ringfenced funded schemes	Slippage for ringfenced funded schemes in 2014/15 to ensure funding received in 2015/16.	31/03/2016	30/06/2015	High Priority

					Discussions with Scottish Government Health Social Care Department Capital Unit will continue regarding management of in year slippage.			
2815	Lindsay Bedford	LWILSO	Risk Register	Capital Forecast	5 year rolling capital forecast 2015-2020 rigorously planned including retention of nbv of sales to increase CRL and approved by Scottish Government Health Social Care Department, and prioritisation of projects.	31/03/2016	30/04/2015	High Priority

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3426	Lindsay Bedford	Lindsay Bedford	Risk Register	One month risk review		18/03/2016			Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1024	Lindsay Bedford	Lindsay Bedford	Risk Register	Six month risk review	-	24/09/2014	01/06/2015	Low Priority	Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2474	Lindsay Bedford	Lindsay Bedford	Risk Register	Six month risk review		28/11/2015	17/02/2016		Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	38
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Agencies working together and with communities to improve services and health outcomes Deliver on the priority areas in our clinical strategy including achieving HEAT targets Improve patient experience of our services

Risk Ownership

Directorate/H&SCP	Chief Executive's Department
Clin. Group/Dept	Corporate Services (Chief Executive)
Title	Information Governance Risk
Description	Failure to comply with Information Governance (IG) legislation and National Standards can lead to damage to the Confidentiality, Integrity, or Availability of personal and corporate information with the consequence of loss of trust of patients, families, the general public and other bodies and action being taken against NHS Tayside by those affected and/or commissioned regulators which could lead to financial loss.
Owner The Owner of the risk is the person who has overall corporate responsibility	Dunning, Margaret - Board Secretary, Ninewells
Manager The Manager of the risk is the person who manages it on the owner's behalf	Dailly, Alison - Information Governance Officer
Last updated	Alison Dailly 03/10/2016 15:54:30

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	25
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Moderate (Category 2)
	Likelihood (current):	Likely - could occur several times
	Rating (current):	12
	Risk level (current):	HIGH
Rationale for Current Score	Additional Requirements June 2015: + DL (2015) 17 Information Governance and Security Improvement Measures 2015-2017 + introduction of new NHSS Information Security Policy Framework July 2015 Additional Risk Feb 2015 - Information Commissioner's Power for Compulsory Audit for NHS Bodies.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Moderate (Category 2)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	9
	Risk level (Target):	MED
Rationale for Planned Score	Specific Roles are required in the Information Security Policy Framework and NHS Tayside has set out the management arrangements to address these in agreement with the Information Governance Committee. The Information Governance Improvement Plan based on the Information Security Policy Framework provides the mechanism by which identified areas of Information Governance threat, vulnerability or weakness will be addressed. Completion of those tasks under the guidance of the Information Governance Committee will reduce the level of likelihood of these events occuring.	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Information security management responsibility, as a distinct function within the IG team, has been implemented following re-organisation of the department to meet the requirements of the Information Security Policy Framework
A separate IS Policy has been developed to comply with the Information Security Policy Framework and sets out standards, roles and responsibilities to maintain the availability, integrity and confidentiality of our systems, data and information at a level appropriate to NHST's needs and in line with current regulatory requirements. This policy has been approved by the IGC and the F&R.
NHS Tayside Information Security Policy - A separate IS Policy has been developed to comply with the Information Security Policy Framework and sets out standards, roles and responsibilities to maintain the availability, integrity and confidentiality of our systems, data and information at a level appropriate to NHST's needs and in line with current regulatory requirements.
NHST has recruited a replacement IGM from 01/06/16 to meet the requirements of the Information Security Policy Framework.
Key Policy Areas: NHS Tayside Information Governance Policy - sets out corporate responsibilities and arrangements to manage Information Governance - amended Jan 2016 to reflect changes required to comply with NHSS Information Security Policy Framework
Data Protection, Confidentiality and Caldicott: NHS Tayside's Data Protection Policy - sets out standards for the use of personal data and guidance on individuals' rights under the Data Protection Act 1998. Caldicott Approval Procedure - sets out responsibilities and arrangements to manage access to patient identifible data. Sharing Information with the Police - Arrangements and Guidance - sets out responsibilities and arrangements to manage information sharing with Police Scotland.
Freedom of Information and Requests for Information: NHS Tayside's FOISA Guide for Information - sets out for the public the arrangments in place for providing corporate information in compliance with the Freedom of Information (Scotland) Act 2002. Staff Guide - Dealing with Requests for Information - sets out standards for the handling of requests for information and guidance on individuals' rights under the Freedom of Information (Scotland) Act 2002.
Information Security: NHS Tayside Information Security Policy - A seperate IS Policy is being developed to comply with the Information Security Policy Framework and will sets out standards, roles and responsibilities to maintain the availability, integrity and confidentiality of our systems, data and information at a level appropriate to NHST's needs and in line with current regulatory requirements. NHS Tayside Use of E-mail and Network Services– sets out standards and responsibilities required by NHS Tayside of users in their use of email and network services. NHS Tayside Portable Computing and Removable Media– sets out responsibilities and arrangements to manage the provision and use of mobile devices and data storage in NHS Tayside. NHS Tayside Information Security Incident Reporting Procedure– sets out responsibilities and arrangements required of NHS Tayside to manage the occurrence of incidents where data or computing facilities are compromised.NHS Tayside System Security Policy and Secure Operating Procedures – sets out the key responsibilities and arrangements to ensure the secure operation and use of individual information systems.
Health Records: NHS Tayside Health Records Management Policy – sets out an overarching framework for integrating health records management and defines a strategy for improving the quality, availability and effective use of health records.

Corporate Records: NHS Tayside Records Management Policy – sets out an overarching framework for corporate records management and defines a strategy for improving the quality, availability and effective use of those records.Creation and Registration of Administrative Records – sets out standards, definitions and requirements that should be applied in the creation and holding of corporate records. Retention Schedules – sets out definitions, minimum requirements, standards and responsibilities for the maintenance and disposal of corporate records. Departmental Records Management Protocol – provides a consistent approach to describing the key records held in specific departments and the arrangements in place to maintain those records.
Key Areas, Officers and Governance: Officers and Governance: Senior Information Risk Owner, Board Secretary, Data Protection, Board Secretary, IG Committee. Confidentiality and Caldicott, Medical Director, Heath Records Committee reporting to IG Committee. Freedom of Information, Board Secretary, Corporate Records Compliance Group reporting to Information Governance Committee. Corporate Records, Board Secretary, Corporate Records Compliance Group Information Governance Committee. Health Records, Medical Director, Heath Records Committee reporting to Information Governance Committee. Data Sharing and Improvement Board, eHealth Director reporting to Information Governance Committee.
Improvement Sept/Oct 2014 - SASPI signed by Local
Information Governance Report 2013/14, 2014/15, 2015/16
Improvement: May/June 2014 - New Systems Access Policy, new CCTV policy
Improvement: Sept/Oct 2014 - SASPI signed by Local Authorities, updated Using email in NHS Scotland; A Good Practice Guide

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Information Governance Committee – meeting quarterly this Committee reports to the Finance and Resources Committee through minutes of meetings and twice yearly reports of progress achieved in meeting the Information Governance Improvement Plan.
INT	Information Governance Improvement Plan agreed and monitored by the Informatin Governance Committee.
INT	Twice yearly Information Governance Improvement Plan progress report provided to the Information Governance Committee.
IA	Internal Audit Reports:T32/15 The Public Records (Scotland) Act 2011 - Preparation of the Records Management Plan. T33/14 Information Assurance – Security of Mobile IT Devices

Gaps in Assurances
What additional assurances should we seek?

No values

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance

September 2016 - A separate IS Policy has been developed to comply with the Information Security Policy Framework and sets out standards, roles and responsibilities to maintain the availability, integrity and confidentiality of our systems, data and information at a level appropriate to NHST's needs and in line with current regulatory requirements. This document has now been approved by both the IGC and the F&R.

July 2016 - The Information Security Maturity Assessment will provide a checklist to benchmark NHST current position against the requirements of the Information Security Policy Framework and will act as an action plan. This proposal was accepted by the IGC in July. Information security management responsibility, as a distinct function within the IG team, has been implemented following re-organisation of the department. NHS Tayside Information Security Policy - A separate IS Policy has been developed to comply with the Information Security Policy Framework and sets out standards, roles and responsibilities to maintain the availability, integrity and confidentiality of our systems, data and information at a level appropriate to NHST's needs and in line with current regulatory requirements.
June 2016 - NHST has recruited a replacement IGM to meet the requirements of the Information Security Policy Framework.
May 2016 - NHST actively recruiting for a replacement IGG to meet the requirements of the Information Security Policy Framework.
Progress against the IGI Plan was reported to the IGC in February 2016 = appointment of SIRO, amendments to IG responsibilities, approval of amended IG Policy, confirmation of ongoing Improvement Measures, assurance that the Information Security Maturity Assessment would form the basis of detailed measurement of improvement.

Agreement on NHS Tayside's Information Governance Improvement Plan based on the Information Security Policy Framework fundamental elements was approved by the IGC September 2015.

Revision of NHSS eHealth Strategy and NHSS Information Security Policy Framework will all impact on NHS Tayside from 2015. All are being considered in NHST Information Governance related plans and developments.

Information Governance Committee reviews the Information Governance Improvement Plan. Committee includes Caldicott Guardians as well as GP & Secondary Care Clinicians. All red and amber operational risks are reviewed at each meeting. Committee also reviews important lessons and actions arising from significant past incidents and the actions taken to prevent reoccurrences.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
84	Ian McDonald	Ian McDonald	Risk Register	Three month risk review		25/03/2014	28/03/2014	
1015	Lindsay Bedford	Lindsay Bedford	Risk Register	Six month risk review	further 6 month review	24/09/2014	29/04/2015	Medium Priority
1413	Lindsay Bedford	Lindsay Bedford	Risk Register	Three month risk review	further 6 month review	13/11/2014	13/11/2014	Medium Priority
2827	Peter Mckenzie	LWILSO	Risk Register	Information Governance Training Material	Review Information Governance training material and establish all topic specific modules in LearnPro to provide consistent, accessible	30/09/2015	01/09/2015	High Priority

					advice to all staff on safeguarding Information Governance principles.			
2816	Peter Mckenzie	LWILSO	Risk Register	Systems Access Policy	New Systems Access Policy in place to establish controls on access to information systems.	30/09/2015	18/09/2015	High Priority
2817	Peter Mckenzie	LWILSO	Risk Register	CCTV Policy	New CCTV Policy in place to establish controls in the use of personal information captured by CCTV.	30/09/2015	18/09/2015	High Priority
2818	Margaret Dunning	LWILSO	Risk Register	2013/14 Annual Information Governance Report	2013/14 Annual IG Report to provide assurance to IGC and F&R of compliance and improvement.	30/09/2015	18/09/2015	High Priority
2820	Margaret Dunning	LWILSO	Risk Register	Scottish Accord for Sharing Personal Information	Scottish Accord for Sharing Personal Information signed by Local Authorities and NHS Tayside established through Data Sharing Board to set out inter-agency data sharing principles.	30/09/2015	18/09/2015	High Priority
2821	Peter Mckenzie	LWILSO	Risk Register	Email - Good Practice Guide	Updated Using email: A Good Practice Guide to establish controls and working practice in the use of email for sending of corporate and personal information.	30/09/2015	18/09/2015	High Priority

2822	Peter Mckenzie	LWILSO	Risk Register	Monitoring of patient level records	FairWarning Privacy Breach Detection application in place to allow monitoring of access to patient level records in ECS and other clinical systems.	30/09/2015	18/09/2015	High Priority
2823	Peter Mckenzie	LWILSO	Risk Register	Information Governance Incidents	Information Governance incidents reported in DATIX, monitored by Informatin Governance Team, reported to Informatin Governance Committee to assess effectiveness of Information Governance controls.	30/09/2015	18/09/2015	High Priority
2824	Peter Mckenzie	LWILSO	Risk Register	Portable Computing/Removable Media	Review of Portable Computing and Removable Media Policy to ensure that controls on mobile and in transit data are effective.	30/09/2015	18/09/2015	High Priority
2825	Peter Mckenzie	LWILSO	Risk Register	Health Records Strategy/Management Policy	Review of Health Records Strategy and Management Policy to ensure standards, practice and controls are set out for the use of Health Records.	30/09/2015	18/09/2015	High Priority
2296	Margaret Dunning		Risk Register	Six month risk review		26/10/2015	19/10/2015	
2828	Lynda Petrie	LWILSO	Risk Register	NHST Records Management practice	Review is underway of NHST Records Management practice in preparation	10/05/2016	06/05/2016	High Priority

					for NHST Records Management Plan to be submitted in compliance with Public Records (Scotland) Act 2011.			
3840	Alison Dailly		Risk Register	Three month risk review	Further three month review	30/08/2016	05/09/2016	High Priority
2826	Margaret Dunning	LWILSO	Risk Register	Data Quality Policy	Establish Data Quality Policy to describe standards and controls required by NHS Tayside in its use of data and information.	01/10/2016	03/10/2016	High Priority
4128	Alison Dailly		Risk Register	Three month risk review		04/12/2016		
4267	Alison Dailly		Risk Register	Six month risk review		01/04/2017		
4126	Alison Dailly	Alison Dailly	Risk Register	DL(2015) 17 - ISPF	DL (2015) 17 Information Governance and Security Improvement Measures 2015-2017 + introduction of new NHSS Information Security Policy Framework July 2015	01/06/2017		High Priority

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	84	Ian McDonald	Ian McDonald	Risk Register	Three month risk review		25/03/2014	28/03/2014		Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1413	Lindsay Bedford	Lindsay Bedford	Risk Register	Three month risk review	further 6 month review	13/11/2014	13/11/2014	Medium Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3840	Alison Dailly		Risk Register	Three month risk review	Further three month review	30/08/2016	05/09/2016	High Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	4128	Alison Dailly		Risk Register	Three month risk review		04/12/2016			Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1015	Lindsay Bedford	Lindsay Bedford	Risk Register	Six month risk review	further 6 month review	24/09/2014	29/04/2015	Medium Priority	Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2296	Margaret Dunning		Risk Register	Six month risk review		26/10/2015	19/10/2015		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	4267	Alison Dailly		Risk Register	Six month risk review		01/04/2017			Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	415
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Building capacity and capability to achieve sustainable change Improve quality of care in all health settings Making the best use of resources and achieving financial balance

Risk Ownership

Directorate/H&SCP	eHealth Directorate
Clin. Group/Dept	eHealth/IT Projects
Title	Implementation of TrakCare
Description	As a result of the Implementation of Trakcare some periods of Service/Business Interruption and/or reductions in functionality may occur during transition from TOPAS which would lead to loss of service. Implementation will require complex service configuration and data transfer operations to occur in conjunction with changes to operational service processes.
Owner The Owner of the risk is the person who has overall corporate responsibility	Bodie, Jenny - Director of eHealth
Manager The Manager of the risk is the person who manages it on the owner's behalf	Graham, Alistair - Head of Service eHealth
Last updated	Alistair Graham 09/09/2016 07:33:39

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Major (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	20
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Moderate (Category 2)
	Likelihood (current):	Likely - could occur several times
	Rating (current):	12
	Risk level (current):	HIGH

Rationale for Current Score	TrakCare has a planned introduction to the organsation and the impact of a new system intriductuiob and assocaited downtime of both systems is a recognised issue which will affect the whole organisation in terms of a temporary loss of service and adjustement to new working practices, although controls are in place to minimise disruption.

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Minor (Category 2)
	Likelihood (Target):	Likely - could occur several times
	Rating (Target):	8
	Risk level (Target):	MED
Rationale for Planned Score	The downtime of both systems is a recognised complication which will affect the whole organisation in terms with the temporary loss of service expected to last 24 hours. Thereafter Trakcare will be available to all clinical areas within NHS Tayside for adoption of the new system and will require a period of adjustment for users.	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Programme Governance - A formal programme governance structure, supported with suitable stakeholder membership and Terms of Reference has been implemented for the TrakCare Executive Programme Board, TrakCare Programme Office, Operational Steering Group and Technical Steering Group
Communication and Engagement Strategy - A formal strategy to support communication and engagement work has been approved by the programme board. The purpose of the CES is two fold:- 1) 1. To support the implementation of the TrakCare aaplication to NHS Tayside 2) 2. To support the complementary changes to operating procedures and working methods necessary to allow the safe implementation of TrakCare to NHS Tayside
Programme Planning and Review - The programme is structured into 3 states, Operational Review, Build and Validation and Adoption. As we approach to completion of the Operational Review stage, the standard programme management process will be adopted for the end of the stage and include, plan review and baselines, success factors review, quality assessment all of which will provide lessons learnt for adoption in the next stage of the programme.
Build and Validation Stage - Particular activities are being planned to carry out significant validation of TrakCare before Go Live. A full 5 months is dedicated to this process to ensure business process, data flow and interfacing capabilities perform as expected. These activities are being planned to include documented evidence of the testing and validation processes carried out
Clinical Safety Officer - Dr Ellie Dow appointed to role. Will pick up hazard report and will report on any identified system deficiencies and plan how we mitigate.

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Finance and Resources Committee

INT	Regular reports will be provided to the Clinical and Care Governance Committee
INT	Programme Board - meet once per month and are accountable to the Finance and Resource Committee. Chaired by Non-Executive. Deputy Chair is Chief Operating Officer. Updates on progress against the programme plan are received from the assigned Operational Lead and Technical Steering Lead in the form of Highlight Reports

Gaps in Assurances
What additional assurances should we seek?

Source	Value
EXT	Internal Audit scheduled for 16/17 (T29/17 NHS Scotland Waiting Times Methodology). It is anticipated that the allocated time may be used for Implementation of TrakCare

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance	Project split into two workstreams both of which report to Programme Board on a risk assessed basis. All key milestones within Project/Implemenation Plan have so far been achieved as planned. The TrakCare programme is currently planned over two Phases. These two phases will result in a go live for all Patient Administration System (PAS) users and ED system users (Phase 1) on 17 February 2017 and Maternity users Phase 2 but impacting on PAS Users and ED users on 19 May 2017. Both these go lives will result in a loss of PAS for an expected period of 20 hours and cause service distribution as all users are supported in the adoption of TrakCare functionality The scale of this programme means there is some inherent risk associated during the phased go live period and with projects of these nature there will be back out plans available as an option.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
4054	Alistair Graham	Hilary Walker	Risk Register	Configure (August - October 2017)	• TrakCare Build • Data Collection and Data Migration • Service Engagement / Change Management • Build non-production system environments • Validate processes • Verify Data Migration • Test Interfaces, Reports, Analytics	31/10/2016		High Priority
4057	Jenny Bodie		Risk Register	Three month risk review		15/11/2016		
4055	Alistair Graham	Hilary	Risk	Adoption (October	• Service	28/02/2017		Medium

		Walker	Register	2016 - February 2017)	Engagement / Change Management • Technical Training • Finalise 'to be' process maps • Build production system environments • User Training • Go Live Cut Over - detailed planning • Complete Data Collection and Data Migration Verification			Priority
4056	Alistair Graham	Hilary Walker	Risk Register	Refine (February-May 2017)	• Go Live Support • Handover to Support organisation in NHS Tayside and InterSystems • Review • Provide process support to bed-in new ways of working • High priority system changes • Project Closure, lessons learned	31/05/2017		Low Priority

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	4057	Jenny Bodie		Risk Register	Three month risk review		15/11/2016			Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	95
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Deliver on the priority areas in our clinical strategy including achieving HEAT targets

Risk Ownership

Directorate/H&SCP	Human Resources
Clin. Group/Dept	Human Resources
Title	Medical Workforce
Description	As a result of the recommended national redesign of the Medical Workforce training (The Greenaway Report), which will result in the reduction of trainees in Acute Services, in addition to graduates leaving the Tayside area and the issue of the medical workforce redesign not being addressed, in due course, the risk of an insufficient supply of trainees and trained doctors and additional financial costs as a result of rotas monitoring non compliant may occur, which would lead to a negative impact on patient care and sustainability of service provision.
Owner The Owner of the risk is the person who has overall corporate responsibility	Doherty, George - Director of Human Resources
Manager The Manager of the risk is the person who manages it on the owner's behalf	Mudie, Jennifer - Associate Director of HR - Resourcing
Last updated	Ian Davidson 07/07/2016 16:24:07

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	25
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Almost certain - could occur frequently
	Rating (current):	20
	Risk level (current):	VHIGH

Rationale for Current Score	Local Workforce Plans are not demonstrating redesign to prepare for the potential reduction in trainees. NHS Tayside is not attracting a full complement of trainees from the national allocation. The challenges of recruiting outwith the national allcoation are many including shortage of supply, concerns around standards and additional costs to cover on a LAS basis. The vacancy factor for junior doctors impacts on the career grade doctor infrastructure. Shortages in similar specialties as those identified for junior doctors exacerbates the situation.

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Moderate (Category 2)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	9
	Risk level (Target):	MED
Rationale for Planned Score	With effective service redesign and role redesign it is possible to reshape the service and its workforce, example of such work is the Shaping Surgical Services Review – the outcome of which is awaited. the Clinical strategies such as those approved by the Board for Mental Health, Maternity Services etc will start to transform the delivery of services and job plans etc	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
New deal monitoring twice per year
Monitoring guidelines for each rota for Trainee
Pre monitoring talks to all trainees
Non compliance rotas reported to Rotamasters (usually an identified Consultant)
Local workforce plans devised by Directorates
NHS Tayside Corporate Workforce Plan
Track progress of report recommending change, becoming policy for implementation through• the North of Scotland Workforce Planning Group for Medical Staff and •• Regular up-dates from Medical Director, Operations who is a member of the national group for the implementation of the Greenaway Report.
Adjusting Consultant on-call rota to ensure adequate senior clinician decision making is available when the more senior ST grades are unfilled
Re-advertising unfilled training posts
Employing Specialty Doctors when redesigning services to minimise gaps in service delivery
PIloting the introduction of Physicians Associates to guage impact on rostering compliance

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Reports to EMT, the Directors' meeting and the Staff Governance Committee/Board as and when changes are forecast, identifying amended workforce plans
INT	The Teaching Training and Management Group for Junior Doctors also receive reports in respect of monitoring exercises and Junior Doctor numbers.
EXT	Reports in respect of compliant rota and monitoring exercises are scrutinised by the National Implementation Support Group.
IA	Periodic Internal Audit Reports
EXT	The National Implementation Support Group approves rota compliance.
EXT	Period Audit Reports

Gaps in Assurances
What additional assurances should we seek?

Source	Value
	None Identified

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance

Greenaway Report has not progressed from recommendation to policy, therefore effort is concentrated on minimizing risk around additional financial penalties in relation to New Deal regulations.
On-going monitoring of compliance in relation to Junior Doctor rota.
Coaching is available to, and ongoing with, General Managers/Clinical Leads around management of trainees in relation to rota compliance. In some areas Heads of Nursing have become involved in setting standards for Junior doctors in relation to time management and learning has been shared with nursing colleagues to ensure junior doctors are not called inappropriately while on breaks.
e-Job Planning has now been implemented and all career grade staff are required to complete electronic job plans. An electronic report will be provided for the Medical Director which will support the analysis of skill mix and capacity of non training posts, thus supporting planning in the event that the recommendations of the Greenaway report become policy.
Annual Corporate Workforce Plan and Workforce Projections on target for June 2016.

To-date little redesign in respect of medical workforce has been evidenced.
The Report on Shaping Surgical Services is awaited and is expected to remodel the medical workforce, current status is that the Option Appraisal, completed at the end of June 2015 indicated 2 options that should be worked up and costed.

National decision in relation to Major Trauma status is awaited.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
334	George Doherty		Risk Register	One month risk review	One month risk review	17/07/2013	13/06/2014	Medium Priority
622	GDOHER		Risk Register	Six month risk review	review date set	02/04/2014	13/06/2014	Low Priority
1243	Jennifer Mudie		Risk Register	Three month risk review	Three month risk review	28/08/2014	06/10/2014	Medium Priority

1453	Jennifer Mudie		Risk Register	Three month risk review	Three month risk review	19/11/2014	21/01/2015	Medium Priority
1960	George Doherty		Risk Register	Six month risk review		20/07/2015	17/03/2015	
2126	Jennifer Mudie		Risk Register	Six month risk review		12/09/2015	05/10/2015	
2832	PMCLOU	Jennifer Mudie	Risk Register	Shaping Surgical Services Review	Shaping Surgical Services Review will describe the future clinical model for surgical and specialist services	31/03/2016	23/06/2016	High Priority
2960	Neil Prentice	Jennifer Mudie	Risk Register	Local Workforce Plans	Local Workforce Plans specifically in relation to redesign of medical workforce	31/03/2016		High Priority
2929	Jennifer Mudie		Risk Register	Six month risk review		02/04/2016	11/04/2016	
2829	George Doherty	Jennifer Mudie	Risk Register	Local Workforce Plans	Local Workforce Plans specifically in relation to redesign of medical workforce	08/04/2016	07/09/2016	High Priority
2831	Andrew Russell	Jennifer Mudie	Risk Register	e-Job Planning	Full Introduction of e-Job Planning to understand medical workforce capacity and service delivery.	30/04/2016	30/04/2016	High Priority
3602	Jennifer Mudie		Risk Register	Six month risk review		08/10/2016		
2959	Michelle Watts	Jennifer Mudie	Risk Register	Local Workforce Plans	Local Workforce Plans specifically in relation to redesign of medical workforce	30/12/2016		High Priority
2830	Jennifer Mudie	Jennifer Mudie	Risk Register	Time/Attendance Module - Junior Doctors	Introduction of time and attendance module for junior doctors – pilot for FY1 and FY2 Junior Doctors	01/03/2017		High Priority

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

						review		

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1243	Jennifer Mudie		Risk Register	Three month risk review	Three month risk review	28/08/2014	06/10/2014	Medium Priority	Y
1	1453	Jennifer Mudie		Risk Register	Three month risk review	Three month risk review	19/11/2014	21/01/2015	Medium Priority	Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	622	GDOHER		Risk Register	Six month risk review	review date set	02/04/2014	13/06/2014	Low Priority	Y
1	1960	George Doherty		Risk Register	Six month risk review		20/07/2015	17/03/2015		Y
1	2126	Jennifer Mudie		Risk Register	Six month risk review		12/09/2015	05/10/2015		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2929	Jennifer Mudie		Risk Register	Six month risk review		02/04/2016	11/04/2016		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3602	Jennifer Mudie		Risk Register	Six month risk review		08/10/2016			Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	58
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Building capacity and capability to achieve sustainable change Deliver on the priority areas in our clinical strategy including achieving HEAT targets Making the best use of resources and achieving financial balance

Risk Ownership

Directorate/H&SCP	Human Resources
Clin. Group/Dept	Human Resources
Title	Workforce Optimisation
Description	As a result of a failure to efficiently and effectively deploy the workforce, the risk of insufficient staffing levels and skill mix may occur, which could lead to a negative impact on the quality of patient care, service delivery and financial balance.
Owner The Owner of the risk is the person who has overall corporate responsibility	Doherty, George - Director of Human Resources
Manager The Manager of the risk is the person who manages it on the owner's behalf	Mudie, Jennifer - Associate Director of HR - Resourcing
Last updated	Jennifer Mudie 13/09/2016 09:00:47

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Likely - could occur several times
	Rating (initial):	20
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Likely - could occur several times
	Rating (current):	16
	Risk level (current):	HIGH
Rationale for Current Score	Failure in this area would have an impact on direct patient care as there would be an increased reliance on supplementary staffing and an impact on NHS Tayside's ability to achieve financial balance. Agency costs are higher as there is insufficient supply of experienced nurses and of Newly Qualified Practitioners. Steps are being taken to reduce the likelihood of problems occurring, however the poor supply levels are a major risk.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Moderate (Category 2)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	9
	Risk level (Target):	MED

Rationale for Planned Score	The controls are mechanisms to support Managers to minimise supplementary and protection costs and to maximize management of redeployment. Additional initiatives and/or improvements that require additional staffing in the current financial year will impact on the objective.

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Redeployment Register and procedure, including Grade Protection Register
Maintenance of sickness absence levels at 4%
Management information to support managers to plan
Non grade protection register for local use by General Managers
Prospective recruitment to minimise supplementary costs as directed by appropriate budget holder or Executive Lead.
Workforce projections to Scottish Government to inform national planning, particularly in respect of national training numbers.
Finance reports identifying staffing costs to management meetings, Area Partnership Forum and Tayside NHS Board
Development of the Corporate Workforce Planning Forum to strengthen understanding of the development of the workforce.
Directorate Performance and Scrutiny Groups led by the Directors of Acute Services, Community Services and Mental Health Services.
Introduction of continuous recruitment for Nurses in the Medicine Directorate
Re introduction of advertisements in the BMJ for hard to fill consultant posts.
Nurse Director to maintain an active Nurse Bank with appropriately skilled Bank Nurses
Roll out of eRostering to maximise the deployment of appropriate skill mix

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Area Partnership Forum: Finance Reports, including staffing costs. Corporate Workforce Plan and Projection Figures. Mid year Report on the Corporate Workforce Plan
INT	Staff Governance Committee: Quarterly Workforce Information reports, identifying information directly relating to workforce data quoted within the Corporate Workforce Plan and an overview of the NHS Tayside data in comparison with the Projections. Corporate Workforce Plan and Projection Figures. Mid year Report on the Corporate Workforce Plan. Quarterly Recruitment Report.Quarterly Sickness Absence Report. Nursing and Midwifery Workload and Workforce Planning Tool report. Reporting on the management of the strategic risks at each of the quarterly Committees

INT	Remuneration Committee: Report on redesign of Senior Manager Posts and organisational structure. Report on financial risk around fixed term contracts and secondments.
IA	Internal Audit Reports
EXT	Scrutiny of NHST Corporate Workforce Plan and Projection statistics by the Scottish Government.

Gaps in Assurances
What additional assurances should we seek?

Source	Value
	None identified

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance

Throughout 2015/16, NHS Tayside has on average employed staff in accordance with the projections for 2015/16, although it is recognized that there have still been vacancies amongst hard to fill nursing posts. However as at 31 March 2016, actual wte is sitting at xxxxxx as oppoosed to the Projected wte at 11871.7.

Supplementary staffing costs are significantly higher than all other Boards. Numbers on the Redeployment/Skills Register have been low.
The overall absence for NHST in Quarter 4 for 2015/16 was 4.911% which was 0.1% higher than in the same period in 2014/15. Long term absence at 2.20% in March 2016 is slightly lower than March 2015(2.39%) by 0.19%. Short term absence at 3.00% in March is higher than March 2015(2.62%) by 0.38%.

Guidance has been circulated to managers to support their appropriate use of fixed term contracts and minimise situations where there is an unnecessary risk of redundancy or redeployment rights.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
136	GDOHER		Risk Register	Three month risk review	Further review required	14/07/2013	13/06/2014	Medium Priority
623	GDOHER		Risk Register	Six month risk review	further review date set	02/04/2014	13/06/2014	Medium Priority
977	GDOHER		Risk Register	Three month risk review	carried out new date set	19/06/2014	08/10/2014	Medium Priority
1400	Jennifer Mudie		Risk Register	Six month risk review		08/02/2015	10/03/2015	
2107	George Doherty		Risk Register	Six month risk review		06/09/2015	09/10/2015	
2834	Lorna Wiggin	Jennifer Mudie	Risk Register	Future Service Delivery	General Managers to plan for the design of future service delivery taking into account Health and Social Care Integration, the opportunities provided by succession planning	31/03/2016	11/08/2016	High Priority

					information and the Clinical Strategy which will be published in 2015/16.			
2956	Jennifer Mudie		Risk Register	Six month risk review		06/04/2016	11/04/2016	
3604	Jennifer Mudie		Risk Register	Six month risk review		08/10/2016		
2835	Vicky Irons	Jennifer Mudie	Risk Register	Current Staff Deployment	General Managers to review current staff deployment to ensure legal and policy compliance including the management of redeployment at local level and maintenance of high standards of service delivery	31/03/2017		High Priority
2836	Vicky Irons	Jennifer Mudie	Risk Register	Third Sector and Volunteering	Maximising opportunities of volunteering, third sector involvement, introduction of co-production across specialties and whole system working through Health and Social Care Integration in order to optimise the workforce.	31/03/2017		High Priority

Risk Reviews

On completing a risk review, remember to set a new risk review date

Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	136	GDOHER		Risk Register	Three month risk review	Further review required	14/07/2013	13/06/2014	Medium Priority	Y
1	977	GDOHER		Risk Register	Three month risk review	carried out new date set	19/06/2014	08/10/2014	Medium Priority	Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	623	GDOHER		Risk Register	Six month risk review	further review date set	02/04/2014	13/06/2014	Medium Priority	Y
1	1400	Jennifer Mudie		Risk Register	Six month risk review		08/02/2015	10/03/2015		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2107	George Doherty		Risk Register	Six month risk review		06/09/2015	09/10/2015		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2956	Jennifer Mudie		Risk Register	Six month risk review		06/04/2016	11/04/2016		Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3604	Jennifer Mudie		Risk Register	Six month risk review		08/10/2016			Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	280
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Deliver on the priority areas in our clinical strategy including achieving HEAT targets

Risk Ownership

Directorate/H&SCP	Nurse Director
Clin. Group/Dept	Nursing and Midwifery Team
Title	Nursing and Midwifery Workforce
Description	As a result of a national shortage and local workforce demographics (Ageing workforce), there is a risk that we will be unable to recruit and retain sufficient numbers of registered nurses which will result in a failure to maintain safe and effective nursing and midwifery staffing levels. Comounding this risk is the launch of NMC revalidation for all registered nurses and midwives from April 2016. NMC ravalidation is mandatory and registration is at risk without active participation. If nurses and midwives fail to maintain registration this could impact on the organisations ability to maintain an adequate registered workforce.
Owner The Owner of the risk is the person who has overall corporate responsibility	Costello, Gillian - Nurse Director
Manager The Manager of the risk is the person who manages it on the owner's behalf	McKenna, Eileen - Associate Nurse Director
Last updated	Eileen McKenna 29/09/2016 12:39:24

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Major (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	20
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Almost certain - could occur frequently
	Rating (current):	20
	Risk level (current):	VHIGH
Rationale for Current Score	Failure in this area would have an impact on ability to deliver safe and effective patient care and is therefore have a major impact on patient safety and experience of care, major financial impact and the reputation of NHS Tayside and is therefore critical. Robust governance processes are essential to reduce the likelihood of these issues occurring.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Major (Category 1)
	Likelihood (Target):	Likely - could occur several times
	Rating (Target):	16
	Risk level (Target):	HIGH
Rationale for Planned Score	While the impact of failures could still have a major impact on patient care and supplementary spend the aim is to reduce the likelihood and consequences of this occurring.	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Proactively recruited Newly Qualified Practitioner (NQP) who will Register in October 2015. Action completed. Currently planning the recruitment of NQP's who will Register in October 2016. Recruitment progressing, Vacancy RAG reports commenced with monthly reporting from service areas, this will facilitate placement of NQPs and identify areas of risk due to vacancies..
Recruitment completed May 2015-06-05 resulting in 173 NQP's recruited which is a 20% increase on previous year.
Utilisation of Bank and Agency staffing monitored on a continual basis. RAG reporting of risk relating to vacancies and timeout being completed monthly and is aligned to supplementary use/spend.
Systematic use of National Nursing and Midwifery Workforce Planning tools to review establishments where appropriate.Programme for 2015/16 being progressed.
Submission of student nurse intake predictions and increase requested (although the impact of this will not be apparent for a period of 3 years)
Corporate workforce plan
Workforce and Care Governance programme
NHS Tayside hosted Scottish pilot for NMC ravalidation between January to June 2015- Complete
Road-show event to raise awareness about the model for revalidation and timelines are being held across the geography of NHS Tayside January 2015 - may 2016
Development and implementation of NHS Tayside Ravalidation Implementation Plan
system to identify and record NMC registrant 3 year renewal/ravalidation dates to be implemented
Support staff through the creation of learning environments that support successful revalidation with the NMC
Implementation of eRostering for all nursing and midwifery teams.
Implementation of Safe Care to enable real time analysis of patient acuity matched to available nurse staffing and identification of any risks.
Nursing and Midwifery Rostering Policy
Proactively recruited Newly Qualified Practitioners who will Register September/October 2016. 212 recruited whish is a further 20% increase on previous year (figure includes 21 Midwives)

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Annual report on use of N&MWP tools to Staff Governance, Directors and Senior Management Team
INT	Monthly time out and supplementary spend data to HoN and Clinical Service Manager
INT	Weekly huddle with leads of Workforce and Care Governance programme with monthly reports to Directors
INT	Senior Managment Team – Nursing workforce issues escalated as and when required.
IA	Internal Audit T23/14 Workforce planning – Nursing & Midwifery
IA	Staffing Report - Grade B awarded.

Gaps in Assurances
What additional assurances should we seek?

No values

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance

Recruitment of Newly Qualified Nurses during 2015 increased by 20%, however not all vacancies were filled and ongoing recruitment is required.

Vacancies being reported and tracked monthly to support the placement of NQPs and identification and managment of risk.

eRostering implementation progressing as per project plan, Safe Care implementation now commenced.

Recruitment of 2016 Nursing Graduates Commenced April 2016. To date (Sept 2016) 212 NQPs have been recruted to substantive posts. Three day induction programme planned to support transition from University Student to NMC Registered Nurse/Midwife working for NHS tayside.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
2705	Eileen McKenna	Eileen McKenna	Risk Register	Map actual and potential staffing gaps	Map actual and potential staffing gaps following recruitment of NQPs and develop recruitment strategies	31/08/2015	31/08/2015	High Priority
2708	Eileen McKenna	Eileen McKenna	Risk Register	Monitor time out and supplementary staffing data	Monitor time out data and supplementary staffing use	30/09/2015	19/10/2015	High Priority
2710	Eileen McKenna	Eileen McKenna	Risk Register	Complete actions detailed in Internal Audit Report	Deliver on all actions highlighted in improvement plan associated with Internal Audit Report	30/09/2015	19/10/2015	Medium Priority
2717	Gillian Costello	Eileen McKenna	Risk Register	Identify and record NMC registrant 3	Develop a system to ensure 3 year	30/09/2015	30/09/2015	High Priority

				year renewal/ravalidation dates	renewal/ravalidation dates are recorded and monitored			
2883	Eileen McKenna	LWILSO	Risk Register	Map Skill Mix Ratios	Map skill mix ratios across organisation to ensure compliance with RN:HCSW ratios.	30/09/2015	30/09/2015	High Priority
2714	Gillian Costello	Eileen McKenna	Risk Register	Review feedback from Pilot	Review feedback from NMC, KPMG, Ipsos MORI and Scottish Government. Use findings to develop implementation plan.	30/10/2015	25/10/2015	Medium Priority
2716	Gillian Costello	Eileen McKenna	Risk Register	Consult on proposed implementation model for NHS Tayside	Consult on proposed implementation model	30/11/2015	13/11/2015	Medium Priority
2718	Eileen McKenna	Eileen McKenna	Risk Register	Identify PD and education resourse to supprt learning environments	Identify PD and education resource to support the learning environment for Registered Staff within NHS Tayside	31/12/2015	13/11/2015	Medium Priority
3860	Eileen McKenna	Eileen McKenna	Risk Register	Recruitment of 2016 Newly Qualified Practitioners	Proactivley engage with University of Dundee and Abertay to maximise recruitment of NQPs. Attend recruitment opportunities of other Scottish Universities to promote NHS Tayside as an employer	30/09/2016	04/07/2016	High Priority
2715	Gillian Costello	Eileen McKenna	Risk Register	Raise registered nurses and midwives awareness of revalidation	Road show events planned from january 2015 Infrastructure for NMC Revalidation established for Tayside; Governance infrastructure in place and progress is reviewed at the Area Partnerhsip Forum (Standing item on the agenda); Learning environment created and staff participating in education events; Staff member secured to particpate in the national webex meetings; Links	31/10/2016	04/07/2016	High Priority

					with the Scottish Government Revalidation Programme Board maintained; First staff Group partipating in revlaidation have successfully achieved revalidation during April 2016.			
3413	Eileen McKenna	Eileen McKenna	Risk Register	Map actual and potential staffing gaps	To facilitate placement of NQP's recruited October 2016 a monthly review of actual and potential vacancies will be completed.	09/12/2016		Medium Priority
3415	Eileen McKenna	Eileen McKenna	Risk Register	Familiarisation Workshops	Programme of Familiarisation workshops scheduled from November 2015 - December 2016	30/12/2016		High Priority
3416	Eileen McKenna	Eileen McKenna	Risk Register	Education to support revalidation	Programme of education to support Registered Nurses with revalidation. Sessions to support Portfolio buidling, refection, professionalism and NMC Code planned during 2016	30/12/2016		High Priority
3417	Eileen McKenna	Eileen McKenna	Risk Register	Education for confirmenrs	Education programme to support staff who are identified as confirmenrs to meet the requirements of the role	30/12/2016		High Priority
2706	Eileen McKenna	Eileen McKenna	Risk Register	Link with National Lead for N&MWWP tools	Link with National Lead for Nursing and Midwifery Workforce and Workload Planning to inform national Nursing & Midwifery Workforce Planning Tools	30/12/2016		Medium Priority
2711	Jenny Bodie	Eileen McKenna	Risk Register	Implementation of e Rostering	Implementation of eRostering for Nursing & Midwifery	30/12/2016		Medium Priority
2713	Eileen McKenna	Eileen McKenna	Risk Register	Ensure compliance with N & M Rostering Policy	Audit compliance with N & M rostering Policy	30/12/2016		Low Priority
4116	Eileen McKenna	Eileen McKenna	Risk Register	Nursing & Midwifery Workforce Planning Education	Review of the current workforce planning module to ensure content is upd to date and supports the building of capacity	31/01/2017		Medium Priority

					and capability of effective workforce planning and use of the nursing and midwifery resource. Plan to run revised module January 2017			
3414	Eileen McKenna	Eileen McKenna	Risk Register	Implement the actions within Atraction & Recruitment Stategy	Implement the actions relating to Nurse & Midwife recruitment within NHS Tasyide Atraction & Recruitment Strategy	28/02/2017		High Priority
3861	Eileen McKenna	Eileen McKenna	Risk Register	Identification of risk due to staffing gaps	Monitoring of staffing issues due to vacancies and time out above agreed parameters in progress through monthly RAG reporting. Immplementation of Safe Care will facilitate real time information and facilitate improved risk managment.	31/03/2017		High Priority
4117	Eileen McKenna	Eileen McKenna	Risk Register	Implementation of Safecare	Implementation of Safecare across all in patient areas to support decision making regards safe staffing levels on a shift by shift basis matched to patient acuity.	30/06/2017		Medium Priority

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

No action chains

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	16
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Improve quality of care in all health settings

Risk Ownership

Directorate/H&SCP	Nurse Director
Clin. Group/Dept	Clinical Governance and Risk Management Department
Title	CLINICAL GOVERNANCE
Description	As a result of failure to deliver reliable, safe and effective care in all health settings unexpected adverse events may occur which would result in harm or deterioration to patients.
Owner The Owner of the risk is the person who has overall corporate responsibility	Russell, Andrew - Medical Director
Manager The Manager of the risk is the person who manages it on the owner's behalf	Napier, Arlene - Head of Clinical Governance and Risk Management
Last updated	Arlene Napier 23/09/2016 11:56:03

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	25
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Possible - may occur occasionally
	Rating (current):	12
	Risk level (current):	HIGH
Rationale for Current Score	Failure in this area has a direct impact on patients' health. It would also impact on organisational reputation and the organisation not meeting legislative requirements if the organisation had to defend its actions in a Court of Law. Whilst we may have one or more adverse events ranging in grade from green to red on a daily basis the proportion of these in relation to our patient activity is minimal. The current score reflects the need to extend controls to all aspects of healthcare including primary care and the HSCPs	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Moderate (Category 2)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	9
	Risk level (Target):	MED

Rationale for Planned Score	Enhanced controls, along with improved systems and processed for AEM, Sharing the Learning and Closing the Loop would reduce the likelihood of an extreme adverse event, although major events would still be possible. We would anticipate that the ongoing work in relation to all aspects of clinical governance outlined in the Clinical Governance Strategy and the Clinical, Care and professional Governance Frameowrk,training and education programmes, performance reviews, use of evidence based practice and robust patient feedback would reduce the frequency of events and the impact these events could have.

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
NHS Tayside approved Clinical Governance Strategy
Regular and comprehensive Performance Management Meetings focused on ensuring that Clinical Governance processes are followed within NHS Tayside, that an audit trail is available on how we are operating Clinical Governance and considering objective evidence in regards to Governance and Performance (including Health and Social Care Integration)
Implementation of Scottish Patient Safety Programmes which include Acute Adult Programme, Mental Health Programme, Primary Care Programme and the Maternity and Children Quality Improvement Collaborative
Implementation of the ten patient safety essentials as set out within CEL 19. The above is supported by the NHS Tayside Patient Safety Network launched in August 2014
Structural arrangements in place from Ward to Board for Clinical Governance which review ongoing Clinical Governance arrangements at every meeting
Adverse Event Management Policy, system and processes
Monthly Senior Management Team meetings focussed on operational system learning from Clinical Governance issues
Weekly Clinical Risk Mangement meetings with Executive Leads
Risk Management Systems and Processes
Action Plans to improve Adverse Event Review; Datix System; CGRM Training
Improvement Programmes - whole system quality improvement programmes in response to: Focus on programme of whole system complex redesign (linked to organisational priorities); Efficiency and productivity programmes (Transformation Programme); Rapid response/closing the loop redesign (response to SCEA, complaints, risk); QI Education Curriculum - building capacity and capability for QI, leadership and organisational development
Self Assessment procsses in place for several aspects of Clinical Governance activites e.g HEI, Older People etc
Staff Training and Education including induction, ongoing and refresher training, revalidation etc.

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Data framework for perfomance reviews from which outputs and emerging risks from Performance Review meetings are reported to Clinical Quality Forum and escalated as required to the Clinical and Care Governance Committee and thereafter to Tayside NHS Board through provision of minutes
INT	Monitoring of the Scottish Patient Safety Programmes and the ten patient safety essentials through Clinical Governance Structures locally and where applicable included within the Performance Review whole system measures. Assurance on individual programmes to the Clinical and Care Governance Committee annually
INT	All Clinical Governance outcomes and data reported and monitored through Qlikview e.g Pressure Ulcers, Nutrition, Falls, AEM, Patient Safety Essentials, Complaints and Feedback
EXT	Quarterly self assessment of Acute Adult, Primary Care, Maternity, Paediatrics and Neonates to Healthcare Improvement Scotland SPSP National Team. Two monhtly reporting of Mental Health Programme to Healthcare Improvement Scotland
EXT	Internal Audit on Clinical Governance - Grade A - July 2015. Also Internal Audit Reports on Risk Management and Adverse Event Management
EXT	Healthcare Improvement Scotland Reviews and Reports
INT	Reporting on adequacy and effectiveness of Risk Management Systems and Processes to Audit Committee biannually
INT	Reports on Person Centeredness and Complaints and Feedback to Clinical Quality Forum and Clinical and Care Governance Committee at each meeting
EXT	Report on Feedback to Scottish Government prepared and submitted annually during Summer months
INT	Internal Audit check of Clinical Effectivenesss Half Days and Systems of Clinical Audit completed within General Surgery

Gaps in Assurances
What additional assurances should we seek?

Source	Value
	Additional measures required within GDET to capture measurement across all Patient Safety Programmes
	As highlighted above, formal KPI reporting to the Clinical and Care Governance Committee is under development.
	Reduced staffing within the Business Unit due to the loss of non-recurring funding is impacting on the level of support available to continue the development of the data framework that supports Clinical Governance from ward to board.
	Improvement plan to be developed to address recommendations contained within Internal Audit Report of Clinical Effectivenesss Half Days and Systems of Clinical Audit (and also considering learning for other Directorates within NHS Tayside)
	Performance review process to be spead to Board functions and HSCPs

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance	Overall NHS Tayside has robust clinical governance and risk systems and processes in place and this is evidenced by Internal Audit Reports (July 2015) and Healthcare Improvement Scotland external review findings and a favourable Scottish Government Annual Review. % or rate of a/e to patient activity % or rate of complaints to patient activity % of SPSO upheld complaints

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority

27	Philip Wilde	Philip Wilde	Risk Register	New Risk Review	Risk reviewed 15th July 2013	30/10/2012	07/08/2013	Medium Priority
485	Andrew Russell		Risk Register	One month risk review	Strategy continues to be progressed and updates as required	06/09/2013	28/10/2013	Medium Priority
678	Andrew Russell		Risk Register	Three month risk review	Risk reviewed by Clinical Governacne and Risk Department 13 June 2014 to bring in line with Board Assurance Framework	26/01/2014	13/06/2014	Medium Priority
1249	Andrew Russell		Risk Register	Three month risk review	completed	11/09/2014	09/10/2014	Low Priority
1692	Arlene Napier		Risk Register	One month risk review	Risk reviewed and updated within system	30/11/2014	16/01/2015	Medium Priority
1947	Arlene Napier		Risk Register	One month risk review	Full review of risk required to be undertaken	15/02/2015	13/03/2015	Medium Priority
2116	Arlene Napier		Risk Register	One month risk review	Review completed	12/04/2015	14/04/2015	Medium Priority
2252	Arlene Napier		Risk Register	Three month risk review	Risk to undergo full review by 14/8/2015	13/07/2015	30/07/2015	High Priority
2651	Arlene Napier		Risk Register	Three month risk review		17/11/2015	09/11/2015	
2659	MMCGUI	Hilary Walker	Risk Register	HSCI	Health and Social Care Governance and professional accountability framework agreed	31/03/2016	19/08/2015	Low Priority
2654	Mrs Dawn Weir	Hilary Walker	Risk Register	Vale of Leven/Grampian	Implementation of Grampian/Vale of Leven Action Plan	31/03/2016	24/03/2016	Low Priority
2655	Diane Campbell	Hilary Walker	Risk Register	Patient Safety	Emphasis shift from the implementation of the ten essentials of safety to the implementation of the nine points of care priorities as per CEL (2013) 19	31/03/2016	06/05/2016	Low Priority
2656	Alan Cook	Hilary Walker	Risk Register	HSCI	Whole systems measurement framework to be developed for CHPs/HSCI and Primary Care	31/03/2016	02/09/2016	Medium Priority
2657	Tracey Passway	Hilary Walker	Risk Register	Locality Clinical Governance Chairs	Education and Training for Locality Clinical Governance Chairs	16/05/2016	10/06/2016	Medium Priority
3643	Arlene Napier		Risk Register	One month risk review	Risk reviewed- remains same at present until more work is underatken around the IJB perfomance and quality reporting for Clinical and Care	26/05/2016	20/05/2016	Medium Priority

					Governance			
2652	Arlene Napier	Hilary Walker	Risk Register	Clinical Effectiveness	Develop clinical effectiveness in line with other NHS Boards	31/05/2016	25/05/2016	Low Priority
2650	Arlene Napier	Hilary Walker	Risk Register	CG Strategy	Full implementation of Clinical Governance Strategy	31/05/2016	28/04/2016	Low Priority
2658	Gillian Costello	Hilary Walker	Risk Register	CQF	Review Clinical Quality Forum Terms of Reference to take in new performance review system	30/09/2016	18/08/2016	Low Priority
4010	Arlene Napier		Risk Register	Three month risk review		03/11/2016		
3296	Arlene Napier	Tracey Passway	Risk Register	Review of Clinical Governance Strategy	Review and refresh of Clinical Governance Strategy (link with care Governance Framework) and Consultation to be undertaken by November 2016. Include formal KPI reporting to the Clinical and Care Governance Committee	30/11/2016		Medium Priority
2660	Gillian Costello	Hilary Walker	Risk Register	Protected Time	Trial of protected time to ensure multi-professional, multi-disciplinary reflective practice Clinical Quality Forum Terms of Reference will reflect a change of format within the meeting. To be discussed with membership on 230516. Matter proposed to commence in September 2016. Change in format agreed and the first participatory learning session is planned for November 2016.	16/12/2016		Low Priority
2653	Michelle Watts	Hilary Walker	Risk Register	Primary Care	Further development of the Clinial Governance Strategy and processes to incorporate Primary Care and results of post-implemetation evaluation	30/12/2016		Low Priority
3661	Arlene Napier	Hilary Walker	Risk Register	Internal Audit Clinical Audit Half Day Improvement Plan	Develop, implement, monitor and review improvement plan to address recommendations contained within Internal Audit Report	31/01/2017		Medium Priority

					on Clinical Audit Half Days.			

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	27	Philip Wilde	Philip Wilde	Risk Register	New Risk Review	Risk reviewed 15th July 2013	30/10/2012	07/08/2013	Medium Priority	Y

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	485	Andrew Russell		Risk Register	One month risk review	Strategy continues to be progressed and updates as required	06/09/2013	28/10/2013	Medium Priority	Y

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1692	Arlene Napier		Risk Register	One month risk review	Risk reviewed and updated within system	30/11/2014	16/01/2015	Medium Priority	Y

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1947	Arlene Napier		Risk Register	One month risk review	Full review of risk required to be undertaken	15/02/2015	13/03/2015	Medium Priority	Y

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2116	Arlene Napier		Risk Register	One month risk review	Review completed	12/04/2015	14/04/2015	Medium Priority	Y

One month risk review

			('From')			point		
1	3643	Arlene Napier		Risk Register	One month risk review	Risk reviewed- remains same at present until more work is underatken around the IJB perfomance and quality reporting for Clinical and Care Governance	26/05/2016	20/05/2(

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	678	Andrew Russell		Risk Register	Three month risk review	Risk reviewed by Clinical Governacne and Risk Department 13 June 2014 to bring in line with Board Assurance Framework	26/01/2014	13/06/2014	Medium Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1249	Andrew Russell		Risk Register	Three month risk review	completed	11/09/2014	09/10/2014	Low Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2252	Arlene Napier		Risk Register	Three month risk review	Risk to undergo full review by 14/8/2015	13/07/2015	30/07/2015	High Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2651	Arlene Napier		Risk Register	Three month risk review		17/11/2015	09/11/2015		Y

Three month risk review

			('From')			action point		
1	4010	Arlene Napier		Risk Register	Three month risk review		03/11/2016	

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	121
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Improve patient experience of our services

Risk Ownership

Directorate/H&SCP	Nurse Director
Clin. Group/Dept	Nursing and Midwifery Team
Title	Person Centreredness
Description	Failure to deliver person-centered care reliably in all health care settings impacting on patient experience of care and organisational reputation.
Owner The Owner of the risk is the person who has overall corporate responsibility	Costello, Gillian - Nurse Director
Manager The Manager of the risk is the person who manages it on the owner's behalf	McKenna, Eileen - Associate Nurse Director
Last updated	Eileen McKenna 31/08/2016 17:58:00

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Likely - could occur several times
	Rating (initial):	20
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Possible - may occur occasionally
	Rating (current):	12
	Risk level (current):	HIGH
Rationale for Current Score	Improving patients experience of care is a key strategic driver and detailed within the Local Delivery Plan. The objective is that Boards should set how services will support a positive care experience with actions to transform the culture to support staff and the public to be open and confident in giving and receiving feedback. Failure in this area could have a major impact on patient experience, and the reputation of NHS Tayside and is therefore critical. Robust governance processes are essential to reduce the likelihood of these issues occurring.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Moderate (Category 2)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	9
	Risk level (Target):	MED
Rationale for Planned Score	While the impact of failures could still have a moderate impact on patient experience of care and organisation reputation the aim is to reduce the likelihood of this occurring	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Nursing & Midwifery Quality Care & Professional Governance Strategy launched Action Plan to be supported by Person Centred Care & Care Assurance Programme
Risks identified and managed through following programmes: Improving Care and Experience; Organisation Values and Behaviours agreed by NHS Tayside Board underpinning a culture of patient and staff engagement reported through Staff Governance Group; Strategic approach to support clinical teams to continually review and improve practice development and implementation of care assurance system
Spiritual care policy and strategic framework ensure access to staff and patients
Feedback risk mitigated through management of complaints, patient/carer experience and staff experience and outcomes
Work ongoing to improve reliability and consistency of reporting of feedback methods and processes
Participation - Volunteers programme in place supporting patients with therapies and access to services managed through participation work stream
Access to independent advocacy service
Interpretation and Translation - Programme of work to ensure reliable system of access to interpretation and translation services in all health care settings
Section 23 workplan

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Ongoing monitoring of patient feedback, comments and concerns through Directorate and HSCP (IJB) Performance Reviews
INT	Annual patient feedback report to Clinical and Care Governance Committee
INT	Annual Person Centered Report to Clinical and Care Governance Committee
INT	Interpretation and Translation Annual Report to Equality and Diversity Steering Group reporting progress with Interpretation and Translation /Section 23 Action Plan
EXT	Healthcare Improvement Scotland (HIS) Inspections and Reviews
EXT	National Patient Experience Programme Reports

EXT	Staff experience and culture/improvement reports
INT	Clinical reviews and triangulation with clinical data
INT	Feedback data

Gaps in Assurances
What additional assurances should we seek?

Source	Value
	None identified

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance

Better Together reporting 91% postive feedback regarding care and treatment for inpatient treatment (increased from 89%).

Complaints rate 1.1 per 1000 patinet contacts with NHS Tayside.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
2719	Eileen McKenna	Eileen McKenna	Risk Register	Programme of education and development	Develop agreed skills and competencies for staff who support improvements in practice with ongoing programme of education/development	30/09/2015	30/09/2015	Medium Priority
2720	Eileen McKenna	Eileen McKenna	Risk Register	Care Assurance Framework	Engagement nationally and locally to agree methodology and measures. Scoping framework to support the measurement of the evidence based 8 Nursing KPI's.	31/12/2015	19/01/2016	High Priority
3375	Eileen McKenna	Eileen McKenna	Risk Register	One month risk review		10/02/2016	17/02/2016	
3431	Eileen McKenna	Eileen McKenna	Risk Register	One month risk review		19/03/2016	04/07/2016	
3427	Eileen McKenna	Eileen McKenna	Risk Register	Establish Person Centred Care & Care Assurance Programme	Person Centred Care & Care Assurance Programme to be established to support delivery of action plan detailed within Nursing & Midwifery Quality Care & Progessional Governance Strategy (2015 - 2017)	31/03/2016	22/04/2016	High Priority
2862	Eileen McKenna	LWILSO	Risk Register	Methodology and Measures	Engagement nationally and locally to agree methodology and	31/03/2016	22/04/2016	High Priority

					measures			
4118	Eileen McKenna	Eileen McKenna	Risk Register	National Patient Experience Survey Results	Review National Patient Experience Survey Results to identify progress and further areas for improvement	12/09/2016		Medium Priority
2721	Eileen McKenna	Eileen McKenna	Risk Register	Standards for responding to complaints and feedback	Develop agreed standards for NHS Tayside responding to complaints and feedback that incorporates a process of quality assurance	30/09/2016		Medium Priority
3430	Eileen McKenna	Eileen McKenna	Risk Register	Develop and implement evidence based care assurance system(s) that improve patients experiences of our services	Using research evidence taking cognisance of national approach described in Excellence in Care, develop, test and implement an agreed care assurance framework	31/10/2016		High Priority
4013	Eileen McKenna		Risk Register	Three month risk review		03/11/2016		
3904	Eileen McKenna	Eileen McKenna	Risk Register	Use of Volunteer for Patient Feedback	Test of right Time patient feedback by use of volunteers to complete telephone interviews post discharge.	30/12/2016		Medium Priority
3428	Eileen McKenna	Eileen McKenna	Risk Register	Establish sustainable and evidence informed ways of listening and learning from all in patients (in the first instance) and their families about their health care experience, reviewing patient feedback methods and developing a toolkit to support systema	• Develop and implement systems and processes to enable patients, carers and the public to provide feedback at all points of care • Implement systems and processes to enable frontline staff to obtain and respond to feedback from patients, carers and families. • Support staff development skills to enable receipt and use of feedback • Work with our academic partners to build capability of student volunteers to gather and report patient feedback • Ensure that the organisational value of feedback, comments, concerns and complaints informs the improving care experience programme by working with stakeholders to ensure that issues raised by staff reviewing practice and learning from	31/12/2016		Medium Priority

					patients experience are actively listened and responded to.			
3429	Eileen McKenna	Eileen McKenna	Risk Register	Support staff to develop skills to support and challenge practice so that it is increasingly person centred, safer and more effective.	• Support staff to use reflection and values based reflection • All grades of practitioners will have access to an active learning group that focuses on learning in and from practice through reflection and critical analysis of their current individual and collective practice • Build capacity and capability to develop practice by ensuring delivery of foundation level practice development education • Provide leadership development for all grades of nursing and midwifery staff • Support staff to deliver the reliable application of Person Centred interventions that underpin the five' Must do with Me' elements • Ensure that dignity and respect frame all communication and interaction with people who use the services of NHS Tayside - Staff will be supported to access programmes that enable them to develop effective communication skills • Work with a range of stakeholders to ensure the environment of care supports the delivery of person-centred care	28/02/2017		Medium Priority

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3375	Eileen McKenna	Eileen McKenna	Risk Register	One month risk review		10/02/2016	17/02/2016		Y

One month risk review

1	3431	Eileen McKenna	Eileen McKenna	Risk Register	One month risk review		19/03/2016	04/07/20

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	4013	Eileen McKenna		Risk Register	Three month risk review		03/11/2016			Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	22
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Get the early years right for every child Optimise the health and quality of lives of people living in Tayside and reduce inequalities

Risk Ownership

Directorate/H&SCP	Nurse Director
Clin. Group/Dept	Nursing and Midwifery Team
Title	HEALTH PROTECTION OF CHILDREN AND YOUNG PEOPLE
Description	Organisational focus is currently limited on the early years and early intervention to improve outcomes for children, young people and families. In addition NHS Tayside is unable to fulfil all its statutory duties contained within the Children & Young People (Scotland) Act 2014.
Owner The Owner of the risk is the person who has overall corporate responsibility	Costello, Gillian - Nurse Director
Manager The Manager of the risk is the person who manages it on the owner's behalf	Wilson, Joan - Chief Nurse - Children & Families,Wallacetown Health Centre
Last updated	Fiona Gibson 18/10/2016 11:47:25

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	25
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Likely - could occur several times
	Rating (current):	16
	Risk level (current):	HIGH
Rationale for Current Score	Failure in this area will have an adverse impact on long-term outcomes for children, young people and adults. It will create increasing levels of 'failure demand' with accompanying financial pressures. Although National Initiatives such as the early years collaboarative, along with the passing of the Children & Young People Act are driving the agenda, the present landscape is dominated by other agendas such as Health and Social Care Integration, financial constraints and waiting time pressures. The creation of a Children, Young People and Families Board, which met for the first time at the beginning of February 2016 will ensure issues concerning children recieve greater prominence at the most senior level within the organisation. The risk has therefore reduced from red to amber. It remains as amber because the impact and benefit of the Children, Young People and Families Board has still to be achieved.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Moderate (Category 2)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	9
	Risk level (Target):	MED
Rationale for Planned Score	The impact of failure could have a major impact on the Board's longer term, population health objectives and on the Board's reputation and financial position (increased expenditure as a result of 'failure demand'). This is less likely if greater focus is given to Children, Young People and Families Services	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Integrated Children's services planning groups x3 - Multi agency planning groups at a strategic level exist in each of the three local authority areas within NHS Tayside representation provided by the Child Health Commissioner (who sits on all 3 groups) and a Child Health Service Manager from the relevant CHP. The General Manager of the relevant CHP also used to sit on these groups and a decision has yet to made regarding how this position will be filled. These groups all report through the 3 Community Planning Partnership structures
Early Years Collaborative Groups (Multi Agency) x3 - The Early Years Collaborative is a national, multi-agency quality imrpovement programme which is led by Community Planning Partnerships. The ambition of the Collaboartive is "To make Scotland the best place in the world to grow up in by improving outcomes and reducing inequalities for all babies, children, mothers, fathers and families across Scotland to ensure that all children have had the best start in life and are ready to succeed." The three Collaboratives in Tayside have identified Programme Managers and NHS staff contribute to the work of all the workstreams. A significant number of tests of change have been undertaken with consideration now being given to issues of scaling up and sustainanility.
Child Protection Executive Group - An NHS Tayside Child Protection Executive Group, chaired by the Nurse and Midwife Director provides assurace to the Board around all matters relating to Child Protection, ensuring continuous improvement in processes and procedures, addressing workforace trainign and supervision requirements, beign alert and ensuring action is being taken on national guidance and ensuring the organisation learns from current research, reports on serious case reviews and other national investigations/reports. The group has developed a Quality Assurance template covering a significant number of domains of Child Protection work.
Tayside Multi Agency GIRFEC Group - In order to ensure a multi-agency pan Tayside strategic approach to Getting It Right for Every Child (GIRFEC), this group has membership from each of the key statutory agencies (Local Authority, NHS and Police) as well as thired sector and Government. NHS Tayside is represetned by the Child Health Commissioner. Chief Executive of Dundee City Council, has recently been appointed tot he Chair and opportunity is being taken to review the workplan.
NHS Tayside GIRFEC Group - Although many aspects of the GIRFEC agenda require to be addressed through multi-agency working, there are nontheless key responsibilities on individual agencies to ensure that the workforce has capacity and is competent to deliver GIRFEC. In addition appropriate processes and systems require to be in place, particularly around information sharing. The NHS Tayside GIRFEC group, charied by the Child Health Commissioner has developed an implementation plan setting out what needs to happen to ensure NHS Tayside is able to deliver its statutory responsibilities contained in parts 4, 5 and 18 of the Children & Young People (Scotland) Action 2014.
Maternal & Infant Nutrition Framework Steering Group - The need to improve maternal nutrition is an effection action to address furture inequalities in health was highlighted in Equally Well and reinforced by the Early Years Collaborative. In 2011 the Scottish Government lauched the 10 years "Improving Maternal and Infant Nutrition: A framework for Action" (MINF). The NHS Tayside MIN Steering Group, chaired by Dietetic Consultant in Public Health has developed a Service Improvement Plan and Measurement Plan to address the following priority areas: Working together; Maternal Obesity; Healthy Start; Infant Feeding and Family Food Skills.
Looked After Children NHS Group - It is well-evidenced that Looked After Children have the poorest outcomes of any other segment of the children and young people population and therefore specific focus is given to this group with the intention of closing the gap between their outcomes and those of their peers. Across Tayside, three multi-agency groups exist to drive forward work in this area, and in addition an NHS Tayside Looked After Children Group exists, chaired by the Child Health Commissioner. The original purpose of the group was to ensure the implementation of CEL 16, addressing the issues of every looked ater child/young person being offered a health assessment. The improvement plan created around this has been delivered and the group is now considering a further workplan.
Transforming Health Visiting - Following the publication of CEL 13, a national scoping exercise was undertaken in April 2013 across all Health Boards to determine the current roles of Health Visitors and School Nurses and what changes were required to respond to emerging evidence, national policy and legislation. As a result of the scoping exercise a National Children & Young People and Families Advisory Group (CYPFAG) was established in late 2013 with 4 priority areas of work (Health Visitor Pathway; Caseload Weighting; School Nurse Pathway; Education & Career Pathways_. An NHS TAyside Implementation Group, chaired by Chief Nurse for Children

and Families has been established to oversee this significant change programme and an implementation plan has been created.
Creation of Children, Young People and Families Board - This Board, jointly chaired by the Nurse Director and Medical Director met for the first time on 2nd February wit a key role of ensuring that outcomes for children, young people and families are improved. Specific remits of the Board will fall into three broad categories - 1) Strategic Planning; 2) Leadership/Governance/Guidance; 3) Models and standards of Care/Risk Management.

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
	The Improvement/implementation plans for most of the above groups are reported through various governance structures, both local and national. Some are reported through Community Planning Partnership governance structuures and other through the NHS Tayside Clinical Qaulity Forum (CQF) and Clinical and Care Governance (CCGC) Committees
	Joint Inspections of Children's Services undertaken by Care Inspectorate

Gaps in Assurances
What additional assurances should we seek?

Source	Value
INT	Some of the groups listed do not currently have a formal reporting structure (e.g. NHS Tayside GIRFEC Group). Some others report solely through CPP structure (e.g. Integrated Children's Services Planning Groups and EYC Groups).
SHA	Progress in implementing the Children & Young People Act (Scotland) 2014 is weak.

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance	There are currently a significant number of change and improvement programmes ongoing in Tayside related to Children, Young People and Families which are delivering positive outcomes, however they exist, at times quite independently of each other and there is a need to create a framework to ensure optimisation of a whole performance across Tayside. The creation of a Children, Young People and Families Board will support this objective. The creation of a Children, Young People and Families Board will allow a forum for more detailed discussion about how Children's Services Planning will be taken forward in NHS Tayside. A paper has been considered by Directors who have agreed to the creation of a Children, Young People and Families Board. Further discussion between the Medical Director, Nurse/Midwife Director and the Child Health Commissioner is due to take place on 18 November 2015. The NHS Tasyide Children, Young People and Families Board has now met on 3 occasions and has agreed the Terms of Reference of the Group which fall into three broad areas: Strategic Planning; Leadership, governance and guidance; and models of standards of care/risk management. The work of the group to date has concentrated on setting out the landscape of Children's services both within the NHS and with our three local authority partners. Decisions will now be taken about appropriate NHS representation on multi-agency groups which will support robust partnership working. Work has also been undertaken to set out the policy context for Children's Services to brief all Board members on the breadth of issues covered. Some aspects of implementing the elements of the Children and Young People (Scotland) Act 2014 are well advanced (eg GIRFEC imlementation) whilst others are less so (eg Corporate Parenting responsibilities and Children's Rights issues). The Board will have oversight over all the elements of the Act.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
32	Philip Wilde	Philip Wilde	Risk Register	New Risk Review		14/09/2012	30/07/2014	
1377	Kay Fowlie		Risk Register	Three month risk review	-	28/10/2014	26/01/2015	Medium Priority
2786	Bill Nicoll	Hilary Walker	Risk Register	Integrated Children's Services Planning Groups	Determine Director level representation on the three integrated Children's Services Palnning Groups	31/08/2015	02/11/2015	Medium Priority
2778	Kay Fowlie		Risk Register	One month risk review	New one month risk review set	16/10/2015	19/10/2015	High Priority
2994	Kay Fowlie		Risk Register	One month risk review		18/11/2015	23/11/2015	
2787	Kay Fowlie	Hilary Walker	Risk Register	Reporting Structures	Review reporting structures of all groups listed	01/12/2015	23/11/2015	Medium Priority
2777	Kay Fowlie	Hilary Walker	Risk Register	Children, Young People and Families Board	Establish a Children, Young People and Families Board to create a framework to ensure optimisation of a whole system performance across Tayside, encompassing all parts of the system delivering on the children & young people agenda.	01/12/2015	23/11/2015	High Priority
3121	Kay Fowlie		Risk Register	Three month risk review	Children, Young People and Families Board met for the first time on 2 February 2016.	21/02/2016	05/02/2016	High Priority
3720	Kay Fowlie		Risk Register	Three month risk review	The Children, Young People and Families Board have considered a draft Driver Diagram and Workplan to provide a framework for the work to be undertaken. It is planned to hold an event in October 2016 for the CYPF Board and additional stakeholders to identify gaps and finalise the workplan. Dundee Children's Services Inspection - A multi-agency Improvement Plan and a single agency Improvement Plan have been produced following the Inspection report. These will be monitored through the Integrated Children's Services Planning Group and the Children, Young People and Families Board. Angus Children's Services Inspection - The formal report has recently been recieved from teh Care	09/08/2016	27/09/2016	High Priority

					Inspectorate and work is now commencing on production of a multi-agency improvement plan and a single agency improvement plan. Discussions are currently ongoing regarding the production of the Children's Services Plans which are legislated for in the Children and Young People (Scotland) Act 2014 and are due to be published in April 2017. The Supreme Court ruling regarding the GIRFEC elements of the Children and Young People (Scotland) Act 2014 has necessitated a delay in implementation of the information sharing elements of the Act.			
2790	Gillian Costello	Hilary Walker	Risk Register	Implementation Plan	Create an implementation plan for all aspects of the Children & Young People (Scotland) Act 2014, agreeing who should lead this work and formal reporting structures. Agreement has been reached to commission a Children's Board, NHS Tayside. Terms of Reference and membership of the Board have been drafted for agreement on 2 February 2016. The first meeting of this group will be held on 2 February 2016. The meeting took place with the next planned for 9 March 2016. The terms of reference were considered by the group on 2 February 2016 and will be endorsed on 9 March 2016. The Terms of Reference provide direction for action to be progressed for the first six months of the Children's Board	01/12/2016		High Priority

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	32	Philip Wilde	Philip Wilde	Risk Register	New Risk Review		14/09/2012	30/07/2014		Y

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2778	Kay Fowlie		Risk Register	One month risk review	New one month risk review set	16/10/2015	19/10/2015	High Priority	Y

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2994	Kay Fowlie		Risk Register	One month risk review		18/11/2015	23/11/2015		Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1377	Kay Fowlie		Risk Register	Three month risk review	-	28/10/2014	26/01/2015	Medium Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3121	Kay Fowlie		Risk Register	Three month risk review	Children, Young People and Families Board met for the first time on 2 February 2016.	21/02/2016	05/02/2016	High Priority	Y

Three month risk review

						Workplan to provide a framework for the work to be undertaken. It is planned to hold an event in October 2016 for the CYPF Board and additional stakeholders to identify gaps and finalise the workplan. Dundee Children's Services Inspection - A multi-agency Improvement Plan and a single agency Improvement Plan have been produced following the Inspection report. These will be monitored through the Integrated Children's Services Planning Group and the Children, Young People and Families Board. Angus Children's Services Inspection - The formal report has recently been recieved from teh Care Inspectorate and work is now commencing on production of a multi-agency improvement plan and a single agency improvement plan. Discussions are currently ongoing regarding the production of the Children's Services Plans which are legislated for in the Children and Young People (Scotland) Act 2014 and are	

						due to be published in April 2017. The Supreme Court ruling regarding the GIRFEC elements of the Children and Young People (Scotland) Act 2014 has necessitated a delay in implementation of the information sharing elements of the Act.				

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	15
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Building capacity and capability to achieve sustainable change Improve patient experience of our services

Risk Ownership

Directorate/H&SCP	Nurse Director
Clin. Group/Dept	Nursing and Midwifery Team
Title	DELIVERING CARE FOR OLDER PEOPLE
Description	Capacity and capability of NHS Tayside and partners to deliver high quality person centered care reliably to older people irrespective of location and in line with Scottish Government's 2020 vision, as per the newly endorsed NHS Tayside Clinical Service Strategy for Older People.
Owner The Owner of the risk is the person who has overall corporate responsibility	Costello, Gillian - Nurse Director
Manager The Manager of the risk is the person who manages it on the owner's behalf	Rodriguez, Cesar - Consultant, POA, SHX
Last updated	Cesar Rodriguez 31/08/2016 15:29:27

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Major (Category 1)
	Likelihood (initial):	Likely - could occur several times
	Rating (initial):	16
	Risk Level (inherent):	HIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Possible - may occur occasionally
	Rating (current):	12
	Risk level (current):	HIGH
Rationale for Current Score	Failure in this area would have an impact on organisational reputation and the organisation failing to meet legislative requirements if the organisations had to defend its actions in a court of law. Reliable older peoples services with robust governance and clinical care governance systems and processes (as per framework agreed by NHS Tayside and partners) are essential to reduce the likelihood of these issues occurring. Improvements made have been corporate and have not yet been implemented operationally, which will be the remit of the three IJBs other than small tests of change but not implemented reliably.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Moderate (Category 2)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	9
	Risk level (Target):	MED
Rationale for Planned Score	While the impact of failures could have a major impact on patient care and organisational reputation the aim is to reduce the likelihood of this occurring.	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
The Older People Clinical Board has devolved executive accountability to define the strategic direction and set the quality standards of healthcare for older people in Tayside, it will also define the competences required by the workforce to deliver person-centred care. Members of the OPCB have the responsibility to contribute effectively to the Board objectives and through an engaging leadership style raise the profile of older people's services. NHS Tayside Board has now endorsed Clinical Services Strategy for Older People, which will inform Acute Services, Primary Care and the three Helath and Social Care Partnerships strategic planning for their older peoples services. The aims of the strategy are:
1. - • Clinical services developed in a multidisciplinary / multiagency framework within the three Health and Social Care Partnerships' organisational and strategic commissioning functions. Such services will provide timely access for older people and people with dementia with appropriate, smooth and evidence-based pathways of care across Tayside.
2. • Clinical services designed to develop and support a compassionate workforce with the appropriate skills and education/training to deliver safe, effective and expert care to older people that maximises their informed decision-making and quality of life.
3. • Clinical services which provide person-centred and evidence based care delivery for older people and people with dementia in collaboration with patients, carers and key stakeholders to achieve optimum clinical outcomes and patient experience in every care setting and for every health-related condition, including end of life care.
To deliver on these aims a number of subgroups have been established and report through Older People Clinical Board:
1. - Locality Model Steering Group -Locality Model/Fraility 2015 Annual Report – endorsed at the October 2015 Older People Clinical Board. Issues around roll-out in terms of funding and temporary positions (affecting continuity of care). Further meetings with NHS Tayside's Director of strategy took place on 10th February 2016 and 11th May 2016 with an action plan to follow. The OPCB meeting on 9th June 2016 was entirely dedicated to discuss progress on NHST Clinical Strategy for Older People. Slower process due to current changes in structures in HSCPs.Next uodate November 2016.
2. - Older People Mental Health Group (including work around dementia) - Clearer remit and reporting of the dementia subgroup now set up. Dementia Diagnosis Pathway out for final consultation and has now been launched and it is available on Staffnet from 12th July 2016. Next update due November 2016.
3.- Transforming District Nursing Group- Vision and model endorsed at the Older People Clinical Board October 2015. Update given at August meeting of the OPCB with a progress update of the National Programme on Transforming District Nursing including role of Band 6 and Caseload, record keeping and IT and Education and Training, Leadership and Development.
Performance & Assurance - Local and National Standards -
1.·Mapping Exercise / Scoping Work was undertaken to understand baseline performance of NHS Tayside against HIS Care of Older People in Hospital 2015 standards; NHS Tayside Older People Clinical Strategy Standards; and PRI HIS OPAH recommendations. Audit completed, discussion with Nurse Director (risk owner) took place 22nd January 2016 and an action plan agreed including a series of roadshows and other strategies to inform an educational and professional framework across Tayside including awareness of the Hospital Standards for Older People. The three roadshows (at Stracathro, PRI and NW) have taken place during June and July 2016 and the first three of the monthly Newsletters has also been produced and sent to all staff. Following the recent HIS unannounced inspection to the care of older people in Ninewells from 7-9 June 2016 with publication on 2nd August 2016, members of the OPCB produced the Action Plan at short notice and the 4-weeks update is being drafted. Update November 2016.
2.·Performance and Assurance Model endorsed at October 2015 Clinical Board. Proposal to utilise the performance review

process to measure success. Recommendations to be shared with NHS Tayside Directors and IJB Chief Officers after OPCB meetings.The OPCB is currently working on a performance framework to inlcude the three HSCPs through their R2 groups when fully formed. Further updates in November 2016.
3.·NHS Tayside is participating in national conversation to understand the implications of Care of Older People in Hospital Standards. Now completed. Further input into the newly formed National Group looking at joint OPAC improvement and OPAH inspections through NHST Associate Medical Director OP membership of this group. Update in November 2016.
Performance & Assurance - Implementation of Medicines Safety and HIS Standard 6 Pharmaceutical Care - Including polypharmacy work in the community, use of antipsychotics in care homes and agreement on prescribing of dementia-delaying drugs across Tayside. On-going work in each locality. OPCB has oversight medicines action plan in relation to older people. Currently reviewing specialist formulary for older people.
Performance & Assurance - Dementia Post Diagnosis Support (PDS) HEAT Target: Reported monthly by NHS Tayside to ISD. In turn this is fed back in management reports to show performance against Scotland other Boards. The PDS service offered by the 3 partnership areas is monitored at 6 weekly Dementia Clinical Improvement Board meetings – a sub group of the Older People Clinical Board. Future work will include developing Quality Principles to demonstrate the effectiveness of PDS. On going in line with national work. Continue monitoring through the dementia subgroup reporting into OPCB.Last report in July 2016 indicates the position of NHST which is favourable as we are achieving higher outcomes than the Scottish average. This will now be reported 3-monthly.
Performance & Assurance - Locality Model and Enhanced Community Service:These represent the pillars to achieve the transformation required to deliver the 2020 vision that NHS Tayside has for the care of older people with the aim to provide care at home, identify older people at risk of decompensation and avoid unplanned/urgent admission to acute settings, as laid out in the NHS Tayside Clinical Services Strategy for Older People. This will be part of each of the HSCPs' performance reviews.

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	The Older People Clinical Board will offer regular reassurance to the Board through the reporting to the Improvement and Quality Committee and the Executive Team, by reporting on the controls listed above. In addition recommendations are being made to NHS Tayside Directors and IJB Chief Officers to utilise performance review processes to measure compliance with standards and escalate any risks through the Older People Clinical Board and operational lines and responsibility.
EXT	- Older People's Services inspections. Currently working on an Improvement Plan following HIS unnanounced inspection to older people's care in Ninewells during 7-9 June 2016.
EXT	- PDS HEAT target (monthly reporting to Government)

Gaps in Assurances
What additional assurances should we seek?

Source	Value
INT	Internal local governance arrangements are required to monitor the implementation of local and national standards. It is proposed that this is the performance review process to ensure local ownership by the Health and Social Care Pertnerships and the operational unit.

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance

There is evidence of very good practice in relation to the care of older people in Tayside and the implementation of pathways and standards is being progressed and monitored. A consistent challenge across all professional groups and evidenced in the recent audit is robust documentation that demonstrates the quality of care being provided.

NHS Tayside is in a positive position in regards to having a central voice for older people's health services as we prepare for Health and Social Care Integration and work closely with the three emerging Integrated Joint Boards to deliver all of the clinical strategy for older people. A dedicated OPCB meeting on 9th June 2016 is scheduled to spedcifically wotk on an implementation p[rogramme for its OP Services Clinical Strategy.

Once performance and assurance framework is in place, overarching NHS Tayside performance will be reported at the Older People Clinical Board which will form part of the update presented at the Clinical Quality Forum. In addition recommendations to utilise the performance review process to understand operational unit performance and risks to deliver national and local standards.

Additional Comments:

Operational management of older people's services will take place within the three IJBs where it is envisaged that the clinical service strategy for older people will be the basis for further joint planning.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
55	Cesar Rodriguez	Cesar Rodriguez	Risk Register	POA Liaison Service in Ninewells Hospital	To agree a model to deliver a comprehensive Psychiatry of Old Age Liaison Service to patients admitted to Ninewells Hospital.	28/12/2012	19/11/2014	High Priority
56	Cesar Rodriguez	Cesar Rodriguez	Risk Register	Prescription and monitoring of antipsychotic medication in people with dementias in care homes in Tayside.	To create a Tayside Group of clinicians and managers to decide the way forward in Tayside following the actions and resulta aof the pilot area (Angus).	22/03/2013	19/11/2014	Medium Priority
57	MMCGUI	MMCGUI	Risk Register	New Risk Review	New Review Date Set	01/04/2013	19/11/2014	Medium Priority
1759	CMCQUI		Risk Register	One month risk review	NA	17/01/2015	19/11/2014	Low Priority
1760	CMCQUI		Risk Register	Six month risk review	NA	17/05/2015	04/08/2015	Low Priority
2998	Cesar Rodriguez	LWILSO	Risk Register	Adoption of Locality Model	The adoption of the "Locality Model" for the care of older people in Tayside has been agreed. This will provide comprehensive, evidence-based and person-centered approach to older	31/12/2015	24/12/2015	High Priority

					people's health care in Tayside.			
3001	Cesar Rodriguez	LWILSO	Risk Register	Priority 1 - Delirium Pathway	1) delirium pathway: completed and approved by OPCB. Appointment of first Delirium Nurse in Scotland. Further ongoing work in relation to identification and management of delirium in acute hospitals required as well as spread to other settings in the community in due course.	31/12/2015	24/12/2015	High Priority
3003	Cesar Rodriguez	LWILSO	Risk Register	Priority 3 - Frail Older Person workstream	3) frail older person work stream: will be carried out as part of the enhanced community model within the agreed MDT meetings where identification of frailty followed by agreed pathways and completion of the comprehensive geriatric assessment will take place as appropriate	31/12/2015	24/12/2015	High Priority
3002	Cesar Rodriguez	LWILSO	Risk Register	Priority 2 - Dementia Diagnosis pathway	2) dementia diagnosis pathway: incorporating best clinical practice and Scottish Dementia Standards to reach a homogenous approach to dementia diagnosis in Tayside.	31/08/2016	31/08/2016	High Priority
3655	Cesar Rodriguez		Risk Register	Six month risk review		25/10/2016		
2997	Cesar Rodriguez	LWILSO	Risk Register	Development of Action Plan	Development of action plan and change/improvement measures following the baseline audit to be completed by December 2015. Implementation of identified improvement measures to be monitored through performance review.	18/11/2016		High Priority
2999	Cesar Rodriguez	LWILSO	Risk Register	Spread of the Locality Model	The Locality Model Steering Group is currently working on the spread of the model in the three areas of Tayside and on an evaluation framework. Different	31/12/2016		High Priority

					areas of Tayside are currently at different stages of this model. This group reports to the Older People Clinical Board.			
3000	Cesar Rodriguez	LWILSO	Risk Register	Endorsement for changes to Older Peoples Services	There is a requirement for NHS Tayside and IJB's to agree a process of endorsement for changes to services for older people that have system wide implications. Recommendations to be made to NHS Tayside Directors and Chief Officers	31/12/2016		High Priority

Risk Reviews

On completing a risk review, remember to set a new risk review date

Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	57	MMCGUI	MMCGUI	Risk Register	New Risk Review	New Review Date Set	01/04/2013	19/11/2014	Medium Priority	Y

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1759	CMCQUI		Risk Register	One month risk review	NA	17/01/2015	19/11/2014	Low Priority	Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	1760	CMCQUI		Risk Register	Six month risk review	NA	17/05/2015	04/08/2015	Low Priority	Y
1	3655	Cesar Rodriguez		Risk Register	Six month risk review		25/10/2016			Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	395
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Improve mental health and mental health services Improve patient experience of our services

Risk Ownership

Directorate/H&SCP	Mental Health Directorate
Clin. Group/Dept	Mental Health Services (Perth and Kinross)
Title	Mental Health Services - Sustainability of Safe and Effective Services
Description	Risks to delivery of Mental Health Clinical Services Strategy - fragmentation and variation in service planning and provision as a result of delegation and hosting of services across 3 IJB localities and NHST 1. Provision and delivery of sustainable 'whole system' high quality safe, effective care and treatment within financial framework. 2. No clear mechanisms for reporting and monitoring of accountability, assurance, governance and continuous quality improvement for clinical care and professional practice standards 3. Availability of required medical and nursing workforce to deliver sustainable safe and effective services for population of Tayside 24/7
Owner The Owner of the risk is the person who has overall corporate responsibility	Russell, Andrew - Medical Director
Manager The Manager of the risk is the person who manages it on the owner's behalf	Packham, Robert -
Last updated	Mark Dickson 20/10/2016 11:58:03

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Likely - could occur several times
	Rating (initial):	20
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Likely - could occur several times
	Rating (current):	16
	Risk level (current):	HIGH

Rationale for Current Score	Failure in this area would have a major impact on organisational reputation and the organisation failing to meet legislative requirements if NHS Tayside has to defend its actions / omissions in a court of law. Medical workforce issues is a medium to long term service level issue that must be addressed through service delivery model redesign

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Moderate (Category 2)
	Likelihood (Target):	Likely - could occur several times
	Rating (Target):	12
	Risk level (Target):	HIGH
Rationale for Planned Score	Compliance with the HSE Improvement Notice; Time bound action plan to address required improvements. Mental health services redesigned to provide sustainable models of care delivery; agreed standards of care and practice monitored through accountable officers in IJBs with robust governance and clinical and care assurance systems and processes to support delivery. Support from Health and Safety advice essential to reduce the likelihood of sources of environmental harm issues occurring	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Day to day service pressures and operational issues posed by workforce shortages across 3 localities being operationally and professionally managed by the senior team in the Directorate through temporary use of Locum psychiatrists
The psychiatric OOHs service delivery model has been redesigned through contingency planning to be provided from Dundee locality for Dundee and Angus patients. Further contingency planning is being progressed to further redesign the OOHs emergency service to be provided from 1 single locality for Tayside if necessary. This will address the potential risks to patient and staff safety caused by the need to identify cover for shortages in 3 medical staffing rotas. A Strategic solution is being proposed to redesign GAP services from 3 sites. NHST Board agreed in March 2016 that services should be redesigned to be delivered from 2 sites or a single site for Tayside. The strategic plan to propose the future model is being developed and a report on the Option Appraisal will be presented to NHST Board in August 2016
HSE - An external review of the Murray Royal Hospital build programme governance has been commissioned by the Chief Executive and Medical Director to identify learning from the process of decision making around the environmental spec. Report has been received but it does not provide anything additional to what was known.
An external professional review of the inpatient deaths subject to the HSE investigation and governance has been commissioned by the Nurse and Medical Directors. There has been a delay on completion of this as the first person commissioned can no longer complete the work. A second person has been commissioned 30th July 2016
Procurement process in place for replacement beds (new beds already in place in Moredun, remainder of adult inpatient estate in process)
Alternative window design identified and discussions with manufacturer progressing regarding supply and fit. Sourcing of solution for door risks being reconsidered as electronic door top alarm solutions have operational risks associated with power failure. Anticipated completion date of remedial works to Moredun Ward and Murray Royal site now February 2017 due to window installation schedule
The environmental risks now subject to the Health and Safety Executive Improvement Notice are being controlled or mitigated through a time bound Action Plan. All inpatient areas were required to have updated Environmental risk assessments completed by end March 2016. This is still an outstanding risk that has not been fully mitigated due initially to capacity in OHSAS Team but now due to absence of necessary expertise since July 2016. External expertise is now being sought.
A detailed review of Datix incidents has been undertaken and identified Moredun ward is a significant outlier in respect of ligature incidents. A bespoke Ward Improvement Support Programme has been developed through The Improvement Team and was delivered between December 2015 and June 2016. Outcomes and Evaluation Report due week ending 12/08/16

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Group set up to specifically redesign the emergency psychiatric OOHs service to address the medical workforce shortages
INT	The environmental risks now subject to the Health and Safety Executive Improvement Notice are being controlled or mitigated through a time bound Action Plan(plan available). This is being progressed through a Mental Health, Health and Safety Group – Fortnightly 'huddles' to discuss and progress actions / Steering Group meeting Bi-monthly.
EXT	Governance around hospital build being reviewed by HFS architect – report received but does not offer any additional information
EXT	HSE investigation complete and report to PF – outcome awaited.
EXT	An external professional review of the inpatient deaths subject to the HSE investigation and governance has been commissioned by the Nurse and Medical Directors (initial commission unable to be completed so work recommissioned 30/06/16 – report therefore still awaited).
EXT	Deanery visit and monitoring of trainee education and evaluation

Gaps in Assurances
What additional assurances should we seek?

Source	Value
INT	Medical workforce issues – gap in assurance and upward reporting and monitoring of vacancy management
INT	Gap in assurance – now resolved; route for upward reporting of progress against HSE improvement notices is through the Clinical and Care Governance Committee
INT	Environmental Risk assessments require to be progressed

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance	Many actions have been taken to control or mitigate environmental risks in the short term. However long term / permanent environmental actions to address known harm sources / risks is slower than estimated. Replacement windows and identification and selection of appropriate and effective solutions for risks from ensuite doors have been thoroughly explored and tested with manufacturers, suppliers and site visits to areas where models are in use to ensure the right alternatives to mitigate risks are selected. The procurement process thereafter is progressing but by the nature of the process that has to be followed, it is expected the Action Plan will not be delivered in full until February 2017 due to the timescales for installation of all windows that need to be replaced, however bedroom windows will be prioritised.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
3866	Grace Gilling	Hilary	Risk	Improvement	Deliver on Ward	30/06/2016	08/08/2016	High

		Walker	Register	Programme	Improvement Support Programme for Moredun			Priority
3870	Karen Ozden		Risk Register	One month risk review		16/07/2016	08/08/2016	
3868	Karen Ozden	Hilary Walker	Risk Register	Governance	Agree route for upward reporting of progress against HSE improvement notices	31/08/2016	08/08/2016	High Priority
4017	Robert Packham		Risk Register	One month risk review		28/09/2016		
3869	Karen Ozden	Hilary Walker	Risk Register	Environmental Risk Assessments	Environmental risk assessments require to be progressed as a priority and updated action plans agreed for each ward.	30/11/2016		High Priority
3865	Karen Ozden	Hilary Walker	Risk Register	Procurement Process	Procurement process for replacement beds, windows and electronic door top alarms across estate.	31/12/2016		Medium Priority
3867	Karen Ozden	Hilary Walker	Risk Register	HSE Action Plan	Fully Implement HSE Action Plan	28/02/2017		High Priority

Risk Reviews

On completing a risk review, remember to set a new risk review date

Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3870	Karen Ozden		Risk Register	One month risk review		16/07/2016	08/08/2016		Y

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	4017	Robert Packham		Risk Register	One month risk review		28/09/2016			Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	144
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Improve quality of care in all health settings

Risk Ownership

Directorate/H&SCP	Medicine Directorate
Clin. Group/Dept	Women and Child Health
Title	Maternity Services
Description	Failure to deliver, safe, effective, person centred care in all maternity settings, in line with Scottish government refreshed framework for Maternity Services (2011).
Owner The Owner of the risk is the person who has overall corporate responsibility	Costello, Gillian - Nurse Director
Manager The Manager of the risk is the person who manages it on the owner's behalf	Craig, Justine - Head of Midwifery, Ninewells
Last updated	Justine Craig 07/09/2016 13:07:45

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Likely - could occur several times
	Rating (initial):	20
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Possible - may occur occasionally
	Rating (current):	12
	Risk level (current):	HIGH
Rationale for Current Score	Failure in this area would have an impact on organisational reputation and the organisation failing to meet legislative requirements if the organisation had to defend its actions in a court of law. Robust maternity services with robust governance and clinical and care governance systems and processes are essential to reduce the likelihood of these issues occurring.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Major (Category 1)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	12
	Risk level (Target):	HIGH
Rationale for Planned Score	While the impact of failures could have a major impact on patient care and organisational reputation the aim is to reduce the likelihood of this occurring.	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Access to continuing professional development.
100% compliance with K2 CTG training package.
Implement and continually evaluate a workforce and service delivery plan.
Reporting outcomes to National MCQIC programme
Public/Service user engagement drop in sessions
Monthly Audit of Sepsis 6 MEWs compliance, documentation and care and Triage activity and quality.
Rota for attendance at Thursday local risk management meetings to ensure widespread learning from incidents
Monthly meetings for band 7 TLs with an HR and finance presence as required
Review of Ombudsman reports, embedding learning
Holding practitioners to account for individual practice, robust risk management process and learning from incidents for the service and individuals
Tayside maternity pathway for all women which encompasses referral pathways for all vulnerabilities, social ,psychological and medical risks.
Multiprofessional maternity workforce and education plan
Real time documentation learning using bespoke tool
Maternity strategic plan in development for next 5 years focus on continuity of carer, appropriate intervention and maintenance and development evidence based guidelines and prectice
Use of 'care rounding' tool in inpatient areas
Supervisor of midwife liason with LSAMO and ratios correct
appointment of band 7 quality and practice development lead
Temporary SCM appointed to ward 38 to improve all required standards eg IC/unicef/clinical care
rapid recruitment to vacancies
Reduction of non clinically indicated antenatal and post natal visits
All guidelines and practice are evidence based and accessible to all relevant staff
Updated clinical governace structure to link with medical clinical governace structure. AN and PN forum and Intrapartum forum , report to Maternity Forum which exception reports to MCG This group is chaired by Consultant Obstetrician and Head of Midwifery and reports into the Medicine Clinical Governance Group. The Medicine Clinical Governance Group is jointly chaired by Associate Medical Director and Associate Nurse Director.
Continuous skills gap analysis based on the skills passport for midwives

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Monthly Clinical Governance Maternity forums
INT	Reports to Strategic Risk Management Group/Clinical Quality Forum
INT	Reduction in preventable harm incidents (Datix)
INT	Reduction in complaints around staff attitude and clinical care

INT	Improved choice and individualised care
INT	Reduction in delays for elective delivery and improved planning of elective workload
EXT	Health Improvement Scotland reviews
EXT	Access to Antenatal Heat target is reported through Information Services Division
EXT	Refreshed Framework for Maternity Services
EXT	UNICEF Baby Friendly Standards
INT	Audit of compliance with McQic measures
IA	Real time documentation audits
INT	Risk news letter now circulated weekly

Gaps in Assurances
What additional assurances should we seek?

Source	Value
INT	Staff feedback
INT	midwifery and obsteric staffing issues . 13wte midwives recruited will commence approx November

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance	Assessment of performance through Work plan and all implemented under the auspices of the Refreshed Framework for Maternity services. Reduction in sickness and absence.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
997	Carol Goodman	Carol Goodman	Risk Register	One month risk review	-	27/04/2014	23/06/2015	High Priority
2868	Antony Nicoll	LWILSO	Risk Register	Training needs - Medical Staff	Skills Gap Analysis to be undertaken for medical staff. Ongoing template will be saved to ensure training needs continue to be identified and addressed. Date for completion of initial skills GAP analysis March 2015 however the work is ongoing.	31/03/2015		High Priority
2870	Justine Craig	LWILSO	Risk Register	HDU criteria	Adopting defined HDU criteria –aim to have a distinguishable HDU area appropriately staffed with midwives who have undergone additional training. Criteria will be ratified by Magic as per guidance. multidisciplinary group currently progressing HDU in maternity including patient follow up feedback and audit	30/06/2015	30/09/2015	High Priority
2873	Justine Craig	LWILSO	Risk Register	Theatre provision/patient journey	Redesign of elective theatre provision and patient journey 30/8/2016 continued issues with theatre provision possibility	30/06/2015	30/09/2015	High Priority

					that maternity emergency theatre is being used for el procedures- audit to commence			
2508	Carol Goodman	Carol Goodman	Risk Register	One month risk review	Current controls are amended to reflect:- Clinical Governance structure in place which reports to the Medicine Clinical governance group . Local arrangements are weekly risk management , monthly local forums , 6 weekly maternity CG group overarching Magic group which Maternity Neonates and Gynaecology report to. This revised structure commences in September 2015. Ongoing professional development , structure for midwives with implementation of the Skills passport which sets out the requirement for every Midwife working in NHS Tayside. Medical staff training structure Leadership development User involvement and feedback ongoing programme in place. MSLC poor attendance other engagement opportunities are being tested Assurances Temporary theatre arrangement in place for elective caesarean section permanent solution required Leadership, compassionate connections, courageous conversations offered to relevant staff Back to Basics programme commencing in August 2015 focus on midwifery care, risk assessment for women in labour Movements Matters and pathway for women presenting with reduced fetal movements Audits of Stillbirth, unexpected admission to the neonatal unit, CMU activity and intrapartum transfers , aromatherapy service , postpartum haemorrhage ,SSI , reflective notes audit (contemporaneous with care) care rounding in Maternity ward, women's feedback collected. Multidisciplinary guidelines, leaflets and training accessible on new Maternity web page Monthly Risk news letter Gaps in controls Medical staff have not completed the skills gap analysis HDU test of criteria commencing October 2015. Test of occupancy complete by multidisciplinary group. Band 7 issue in 3 areas , mitigation in place to reduce risk . Additional workload with no additional funding	23/07/2015	27/08/2015	Medium Priority

					with implementation of the Growth Assessment Protocol , escalated to ND. Mitigation- is not to implement yet but prepare to implement. Medical obstetric rota.			
2869	Justine Craig	LWILSO	Risk Register	Enhanced Leadership Skills	Support for enhanced leadership skills until September 2015.Ongoing work will also take place with band 6 midwives.	30/09/2015	30/09/2015	High Priority
2874	Justine Craig	LWILSO	Risk Register	OD Programme	Supporting a culture of trust and openness supported OD programme funded by refreshed framework and being pilot site for compassionate connections and I matter	30/09/2015	07/09/2016	High Priority
2872	Justine Craig	LWILSO	Risk Register	I.T. System	Review of IT System as this impacts on flow, capacity and discharge. Working with the Business hub to ensure we are utilizing IT to its fullest potential for clinical care, audit and service planning.	30/09/2015	30/09/2015	High Priority
2687	Carol Goodman	Carol Goodman	Risk Register	Six month risk review		23/02/2016	01/09/2016	
2865	Justine Craig	LWILSO	Risk Register	Maternity Web Page	Plan to ensure guidelines are easily accessible on Maternity web page. Governance of process and compliance held with guideline group reporting to MAGIC. Following completion date this will be an ongoing process for every new/updated or amended guideline	31/03/2016	30/09/2015	High Priority
2867	Justine Craig	LWILSO	Risk Register	Midwives training sessions	Back to Basics training sessions for Midwives, ensure the most basic standards of care for women in pregnancy birth and the puerperum are to the highest standards, students receive high quality training in NHST .Audit and evaluate .This will be a continuing programme aligned with the PROMPT and professional 2 day mandatory training.	31/03/2016	03/09/2015	High Priority
3384	Justine Craig	Justine Craig	Risk Register	Neonatal transfer procedures for stable unwell neonates from CMUs	Current waiting times for neonatal transport team may be very long up to several hours. Plan link with SAS and Scotstar to seek possibility of being able to upgrade urgency if there is deterioration of the baby This is a complex national issue	01/09/2016	02/09/2016	High Priority
2871	Justine Craig	LWILSO	Risk Register	LAER/SCEA learning	Embed process to disseminate learning from LAER and SCEAs	30/09/2016	07/09/2016	High Priority
4121	Justine Craig		Risk Register	One month risk review	strategic risks reviewed and updated	01/10/2016	30/08/2016	High Priority

2866	Justine Craig	LWILSO	Risk Register	Reduce unnecessary interventions	Reduce unnecessary interventions in line with National Guidance with a plan to increase normal births where appropriate. Utilise Qlikview dashboard to observe, identify and action intervention trends where required. Ensure consistency of local guidance by professionals.	31/12/2016	30/08/2016	High Priority
3383	Justine Craig	Justine Craig	Risk Register	Implementation of Maternity TRAK care	Plan to implement Maternity IT system and unify electronica approach. Concern that it will not integrate with EMIS and other IT systems relevent to Maternity	08/05/2017	30/08/2016	High Priority

Risk Reviews
On completing a risk review, remember to set a new risk review date
Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	997	Carol Goodman	Carol Goodman	Risk Register	One month risk review	-	27/04/2014	23/06/2015	High Priority	Y

One month risk review

						involvement and feedback ongoing programme in place. MSLC poor attendance other engagement opportunities are being tested Assurances Temporary theatre arrangement in place for elective caesarean section permanent solution required Leadership, compassionate connections, courageous conversations offered to relevant staff Back to Basics programme commencing in August 2015 focus on midwifery care, risk assessment for women in labour Movements Matters and pathway for women presenting with reduced fetal movements Audits of Stillbirth, unexpected admission to the neonatal unit, CMU activity and intrapartum transfers , aromatherapy service , postpartum haemorrhage ,SSI , reflective notes audit (contemporaneous with care) care rounding in Maternity ward, women's feedback collected. Multidisciplinary guidelines, leaflets and training accessible on new Maternity web page Monthly Risk news letter Gaps in controls Medical staff have not completed the skills gap analysis HDU test of criteria commencing October 2015. Test of occupancy complete by multidisciplinary group. Band 7 issue in 3 areas , mitigation in place to reduce risk . Additional workload with no additional funding with	

						implementation of the Growth Assessment Protocol , escalated to ND. Mitigation- is not to implement yet but prepare to implement. Medical obstetric rota.				

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	4121	Justine Craig		Risk Register	One month risk review	strategic risks reviewed and updated	01/10/2016	30/08/2016	High Priority	Y

Six month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2687	Carol Goodman	Carol Goodman	Risk Register	Six month risk review		23/02/2016	01/09/2016		Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	302
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Agencies working together and with communities to improve services and health outcomes Deliver on the priority areas in our clinical strategy including achieving HEAT targets Making the best use of resources and achieving financial balance

Risk Ownership

Directorate/H&SCP	Directorate of Acute Services
Clin. Group/Dept	Business Unit
Title	PRI/Patient Flow
Description	Insufficient resilience at Perth Royal Infirmary to cope with fluctuations in unscheduled demand therefore there is a risk that patients will: Not have access to the right care, in the right place, at the right time Experience harm from corridor waits Be cancelled for elective procedures Experience harm and delay through being treated and cared for outwith specialty Be diverted to Ninewells Hospital when bed capacity is exhausted This could result in reputational damage to the organisational as a result of being unable to fulfil its commitments to patients, organisational objectives and achieve its HEAT targets and standards.
Owner The Owner of the risk is the person who has overall corporate responsibility	Cook, Alan - Consultant Radiologist (Associate Medical Director)
Manager The Manager of the risk is the person who manages it on the owner's behalf	Wilson, Kerry - General Manager, Perth Royal Infirmary
Last updated	Kerry Wilson 04/10/2016 10:01:17

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	25
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Likely - could occur several times
	Rating (current):	16
	Risk level (current):	HIGH

Rationale for Current Score	The current risk score highlights the current situation which has been evident for the past 12 months. The situation described has resulted in significant impact on patients, service provision and NHS Tayside HEAT targets and standards performance has deteriorated as a result. This was confirmed at Clinical and Care Governance Committee on 11.02.16 The seven measures forming a risk stratification score have been developed and presented and endorsed at the Clinical and Care Governance Committee on 12 May 2016. These demonstrate that the whole system risk has reduced slightly over recent months. In addition, additional funding from the P & K Partnership to fund 60 patients for care at home and care homes was released on 12 May 2016. This again reduces the risk slightly, however, it is recognised that there are ongoing challenges with provision of care at home. Risk reviewed on 7/7/16. The May 2016 overall risk score has reduced further to 10. The weekly meeting to review the level of delayed discharge and increasing maturity of partnership working has resulted in a reduction of patients delayed. Winter surge beds were stepped down on 27 June 2016.

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Major (Category 1)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	12
	Risk level (Target):	HIGH

Rationale for Planned Score	By implementing the identified mitigating actions the aim is to appropriately manage and improve the situation which should result in the situation recurring on a much less frequent basis. This was confirmed at Clinical and Care Governance Committee on 11.02.16

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Daily Safety Huddles implemented since October 2015 in addition to the Capacity and Flow calls
Consultant recruitment completed, with the third post commenced 15.02.16
Monthly consultants meetings continue- Chaired by Director of Acute Services or Medical Director, Delivery Unit
PRI Dashboard implemented and endorsed by Clinical and Care Governance Committee on 11.02.16
General Manager commenced November 2015, and Associate Nurse Director aligned to PRI

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	PRI Dashboard information - considered as part of performance review and also reviewed by Director of Acute Services on a weekly basis

INT	Delayed discharge report - reviewed twice daily, 7 days per week as part of capacity and flow calls
EXT	National Day of Care Audit

Gaps in Assurances
What additional assurances should we seek?

Source	Value
INT	The Business Unit may have insufficient capacity to provide the information

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance

There were 60 patients who could waited for admission (corridor wait)in December 2015
There was an average of 29 patients daily who were boarded during December 2015
A total of 72 patients are experiencing a delayed discharges across Perth & Kinross acute, community and mental health wards at 16.02.16 (24 patients in PRI)
38 elective patients cancelled in December 2015
Performance at December 2015 - 4 hour standard within A&E at 98.8%
The May 2016 Performance for 4 hour standard was 99%, number of patients waiting for a bed fell further to 20, bed occupancy fell to 75% (winter surge beds remained open at this time), boarding fell to an average of 17 with no elective cancellations.

The June 2016 risk stratification score was has been used to assess the current risk exposure rating. This had previously reduced, mainly due to the additional funding from the P & K Partnership which had to support delayed discharge position. In addition, teams across health and social care are working together to improve discharge management. The risk exposure rating has not been reduced and remains at 12 due to the ongoing issue of providing timely care at home packages which continues to impact on hospital flow and delay to discharge.

Risk Review undertaken on 29 August 2016 using local intelligence based on the volume of patients admitted, no further reduction in patients experiencing a delayed discharge mainly due to the lack of care at home packages which has resulted in patients transferred for non-clinical reasons (boarding). As a result, the risk exposure rating has been increased back to 16. A further review will be undertaken when the data is reported to inform the risk stratification score.

Further review following the August 2016 data being reported has confirm no reduction to the risk rating. The August 2016 data within this report and the weekly management information for September 2016 shows a deteriorating position across 3 of the risk measures. There has been a requirement to open up to 8 which are not part of a funded establishment and a result agency costs have increased. The delayed discharge position has worsened over the last month with continued inability to provide timely care at home packages. There has also been an elective cancellation.

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
2918	Lorna Wiggin		Risk Register	One month risk review	General Manager appointed to the PRI site to support improvements in patient care and flow. Due to commence on site 2nd November 2015.	16/10/2015	09/10/2015	High Priority
2914	Lorna Wiggin	Hilary Walker	Risk Register	General Manager	Recruit General Manager for PRI	31/10/2015	29/10/2015	High Priority
2916	Kerry Wilson	Hilary Walker	Risk Register	Discharge Pathway	Develop/improve pathway for discharge.	31/12/2015	19/09/2016	Medium Priority

2917	Tracey Williams	Hilary Walker	Risk Register	Hospital Huddle	Daily hospital huddle to be implemented	29/01/2016	23/11/2015	High Priority
3685	Kerry Wilson		Risk Register	Three month risk review		01/08/2016	07/07/2016	
3286	Jim Foulis	Kerry Wilson	Risk Register	Nursing workforce meets recommended levels	Recommended levels based on outpurs of nursing workforce tools Target recrutiment and retention approaches	31/10/2016		High Priority
4014	Kerry Wilson		Risk Register	Three month risk review		03/11/2016		
2915	Kerry Wilson	Hilary Walker	Risk Register	Accommodation	Plan to revise PRI accommodation footprint to ensure it remains fit for purpose	25/11/2016		Medium Priority

Risk Reviews

On completing a risk review, remember to set a new risk review date

Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	2918	Lorna Wiggin		Risk Register	One month risk review	General Manager appointed to the PRI site to support improvements in patient care and flow. Due to commence on site 2nd November 2015.	16/10/2015	09/10/2015	High Priority	Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	3685	Kerry Wilson		Risk Register	Three month risk review		01/08/2016	07/07/2016		Y

Three month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	4014	Kerry Wilson		Risk Register	Three month risk review		03/11/2016			Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Hilary Walker

Datix

Risk Form

CLICK HERE to view the NHST Risk Management Guidance Note

Risk Description

RISK ID	414
Type of Risk Only Directors may add Strategic Risks	Strategic Risk
Principal objectives	Building capacity and capability to achieve sustainable change Improve patient experience of our services Making the best use of resources and achieving financial balance

Risk Ownership

Directorate/H&SCP	Primary Care
Clin. Group/Dept	General Practice
Title	Managed/2C Practices
Description	As a result of an increase in GP vacancies due to retirement and difficulties being experience in relation to recruitment and retention, there is a risk that NHS Tayside will be unable to provide General Practitioner cover to a number of Practices across the geographical location and provide continuity of service, which may lead to adverse publicity, reputational damage and unsatisfactory patient experience.
Owner The Owner of the risk is the person who has overall corporate responsibility	Russell, Andrew - Medical Director
Manager The Manager of the risk is the person who manages it on the owner's behalf	Watts, Michelle - Associate Medical Director - Primary Care
Last updated	Hilary Walker 12/08/2016 13:48:50

Inherent Risk Exposure Rating

Inherent Risk Exposure Rating Assessment of the risk without any controls in place.	Consequence (initial):	Extreme (Category 1)
	Likelihood (initial):	Almost certain - could occur frequently
	Rating (initial):	25
	Risk Level (inherent):	VHIGH

Current Risk Exposure Rating
Assessment of risk at time of risk review.

Current Current assessment of risk. To be updated when the risk is reviewed	Consequence (current):	Major (Category 1)
	Likelihood (current):	Almost certain - could occur frequently
	Rating (current):	20
	Risk level (current):	VHIGH
Rationale for Current Score	Situation is already occurring within NHS Tayside where there has been loss of services and contingency plans have been evoked.	

Planned Risk Exposure Rating

Planned Risk Exposure Rating Anticipated risk grading after all mitigating actions have been implemented.	Consequence (Target):	Major (Category 1)
	Likelihood (Target):	Possible - may occur occasionally
	Rating (Target):	12
	Risk level (Target):	HIGH
Rationale for Planned Score	Situation is already occurring within NHS Tayside where there has been loss of services and contingency plans have been evoked and although mitigating actions are being progressed it is too early to predict what the longer term effect of these will be.	

Current Controls
This should reflect the current mechanisms you have to control the risk. Think about: Management – systems/structures/monitoring mechanisms e.g meetings, training, additional staff appointments already made. Policy and Procedure – Policies and procedures in place to control the risk Contingencies – emergency plans/alternative arrangements that intervene should the risk become apparent Action – Implementation of immediate actions e.g timetables, actions plans, project plans etc External controls/guidance – Legislation, national directives, best practice Whilst difficult to judge with precision, the key controls are those that mitigate the risk from its inherent level to its current level. If a control does not have that level of impact then it should be recorded on an operational risk (below) but not necessarily included here.

Value
Senior leadership general practitioner posts agreed and advertised internally and on show. Post on rolling recruitment programme and requires WTE appointment with clinical commitment and demonstrable leadership experience
Buddy system e.g. Terra Nova and Whitfield
SLA for interpractice cover
Job description agreed for ANP
4 physician associates – consider training for placing into primary care for Phase 2
Evolution of cluster practices
Cluster Leads
National Health Service (Scotland) Act 1978
Funding for Staff Governance for Quality Leads
NHS Tayside Workforce Plan
Primary Care currently incorporated into each IJB
Practice visiting process in place
NES GP recruitment scheme (includes retainers, returners & overseas)
Primary Care Strategy
GP High Level Workforce Plan Outline
National Health Service (Scotland) Act 1978

Assurances
Please provide details of Reports to the delegated Standing Committee which provide information on how the key controls above are operating in practice or direct data on the status of the risk e.g. performance data. A review of the reports which do go to the Standing Committee will identify assurances. However, there must be consideration of whether the reports as they are currently constituted actually provide direct assurance on the operation of the key controls and whether they are constructed in such a way as to ensure that this is highlighted, noting the GGI view that specifically commissioned assurance is the most powerful. Where a control is being operated within a sub-group, it is not enough for minutes to be presented. The areas where assurance on key controls is being provided should be overt and unequivocal

Source	Value
INT	Primary Care reporting to CQF and Clinical and Care Governance Committee - framework is in place and reporting through Clinical and Care Governance Groups R3 to R2 to R1 - Joint Professional Forum (Not fully in place in each partnership)
INT	Reporting through Executive Group since CHP arrangements dismantled
INT	Reporting through Directors and SMT meetings by Chief Officer, Angus IJB

INT	Assurance from practice visits - reporting through Primary Care Risk Management Committee
INT	Practices in Difficulty monitoring and monthly written report to Board informs of closed lists/changes in boundaries. This is also circulated to Directors
INT	Weekly meeting via teleconference of OOH/SAS/IJBs to discuss operational risks and staffing issues
INT	Standing Agenda Item at GP Advisory Committee on quarterly basis
INT	Associate Medical Director for Primary Care provides a verbal update on a monthly basis at GP Sub Committee which submits minutes to the Area Clinical Forum
INT	Monthly Report on all Primary Care Services to Angus IJB Executive Meeting (Chief Officers of Dundee and Perth also receive copies)
EXT	Internal Audit Report 2015 T16/15 - 20:20 Priorities - Primary Care
EXT	Each Independent Contractor is subject to Inspections by the Regulatory Bodies

Gaps in Assurances
What additional assurances should we seek?

Source	Value
INT	Establishment of Performance Review system specifically for Primary Care

Current Performance
Set out an assessment of how well the risk is currently being mitigated and controls being applied effectively. If possible, very high level performance and other data which outline current status and provide a judgement on whether this is in line with expectations would reinforce the conclusion.

Current Performance	There are currently 3 managed/2C practices within NHS Tayside (Lochee, Whitfield and Brechin) with challenges already being highlighted at Terra Nova (looking to cap lists) and Hillbank (2 GP retirements July 2016)

Mitigating Actions (Gaps in Control)
These are the future actions which will bring the risk down from its current to its planned level. If an action is not likely to have this impact, then it may not be necessary to include it so that attention can be focused on the most important controls. If the list of actions will not in themselves bring the risk down to the required level then this should be identified, with a clear statement of what future work will be done to identify the actions required. If conversely, there are no actions which will take the risk down to its planned level then the planned risk is unachievable and should be amended with explanation.

ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority
4028	Michelle Watts	Hilary Walker	Risk Register	Medical Advisor	Primary Care Medical Advisor to IB to be agreed	31/08/2016	29/08/2016	Medium Priority
4041	Michelle Watts		Risk Register	One month risk review	2c practices: whitfield- successful recruitment to vacant GP post. exploring opportunity re merger with another Dundee practice facing sustainability issues. CLO advice sought. Lochee- recent appointment to leadership GP post and new P/T academic GP. Interviews this week for remaining post.practice development plan in progress. Test of NP role, recruitment to admin posts brechin: significant GP workforce challenges remain- as of Oct 1.1 wte (recommended 4.8). locum availability improving, MDT working well	11/09/2016	29/08/2016	High Priority
4031	Sue Mackie	Hilary	Risk	Risk Assessments	Practice Risk Assessments	30/09/2016	07/10/2016	Medium

		Walker	Register		to be carried out.			Priority
4029	Michelle Watts	Hilary Walker	Risk Register	Self Assessment Matrix	Risk Matrix to be sent to all practices to self assess themselves	30/09/2016	14/09/2016	High Priority
4030	Michelle Watts	Hilary Walker	Risk Register	Senior Management	Plan to appoint senior management support at practice manager level	31/10/2016	14/09/2016	High Priority

Risk Reviews

On completing a risk review, remember to set a new risk review date

Risks must be reviewed on a regular basis, either monthly, three monthly, six monthly, nine monthly or yearly.

One month risk review

Step	ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Details of action point	Due date	Done date	Priority	Active
1	4041	Michelle Watts		Risk Register	One month risk review	2c practices: whitfield- successful recruitment to vacant GP post. exploring opportunity re merger with another Dundee practice facing sustainability issues. CLO advice sought. Lochee- recent appointment to leadership GP post and new P/T academic GP. Interviews this week for remaining post.practice development plan in progress. Test of NP role, recruitment to admin posts brechin: significant GP workforce challenges remain- as of Oct 1.1 wte (recommended 4.8). locum availability improving, MDT working well	11/09/2016	29/08/2016	High Priority	Y

DatixWeb 14.0.5.1 © Datix Ltd 2015

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

NHS Tayside

BOARD115/2016
Tayside NHS Board
27 October 2016

ASSURANCE REPORT ON INFECTION MANAGEMENT RISK

1. STRATEGIC RISK

The Board Assurance Framework Strategic Risk Profile and individual risk reports from DATIX aims to identify the Strategic Risks that could impact on the delivery of NHS Tayside's objectives. The risk to which this report relates is the Infection Management Risk with the principle objective being to provide care in a safe and clean environment.
Failure to comply with Infection Control national standards, policies, guidance and practice could impact on patient care and service delivery and lead to adverse reputational consequences with the loss of confidence of patients, families and the general public.

2. CURRENT PERFORMANCE

Current performance against this risk is updated as a minimum 6 monthly and is highlighted in the table below:-

Datix Ref	Risk Title	Lead Director	Inherent Risk Exposure	Date of Last Update
14	Infection Management	Nurse Director	20 (5x4) Very High	August 2016

The rationale for the current score reflects the consequence and likelihood which are automatically generated within the Datix system.

3. ASSURANCE

The current controls in place to mitigate this risk are set out in the DATIX report. These principally reflect the current mechanisms and actions that are being taken by the Infection Control and Management Team within NHS Tayside.

By having infection control as an agenda item at both strategic and operational performance fora as well as the presentation of a detailed HAI Report at each NHS Tayside Board meeting offers a level of assurance of collaborative working coupled with monitoring and surveillance for the management of this strategic risk.

4. CONCLUSION

The Infection Control & Management Team will continue to work collaboratively to promote clinical and non-clinical staff to recognise and understand their key role in being able to provide care in a safe and clean environment.

Mrs D Weir
General Manager
Infection Control and Management

Mrs G Costello
Nurse Director
HAI Executive Lead

Ms L McLay
Chief Executive

October 2016

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item 8.6.2

BOARD116/2016
Tayside NHS Board
27 October 2016

ASSURANCE REPORT HEALTH EQUITY RISK

1. STRATEGIC RISK

In 2010 NHS Tayside Health Board supported the implementation of a Health Equity Strategy (Communities in Control). Failure by NHS Tayside and its partners to fully implement the recommendations of this strategy, and to prioritise health equity issues in decision making, will ultimately result in failure to achieve the corporate strategic objective to reduce the health equity gap in Tayside within a generation.

While there was evidence of service improvement work having been undertaken since the implementation of the strategy to address health inequalities, there were concerns that this had not happened in a systematic way nor had the activity undertaken been captured and reported. The Director of Public Health took the decision to record the full implementation of the strategy as a risk on the Datix risk management system in 2015.

NHS Tayside Audit Department undertook an audit (Report T17/15 – Health of the Population – Health Equity Risk) which considered the risks associated with non-implementation of the Strategy. The report was given a 'Category D; Inadequate' grading. The report included a response to the recommendations contained within the strategy and, in collaboration with the Public Health Directorate, outlined the actions proposed to address the current deficiencies in the form of an action plan.

2. CURRENT PERFORMANCE

Recent and current performance against this risk is highlighted in the table below:-

Datix Ref	Risk Title	Lead Director	Inherent Risk Exposure	April 2015	Oct 2015	Feb 2016	May 2016
201	Health Equity	Director of Public Health	25 (5x5) Very High	16 (4x4) High	16 (4x4) High	12 (3x4) High	12 (3x4) High

NHS Tayside Board are asked to note the main changes made since the last report;

The Current Risk Exposure Rating has changed from 'Likely' to 'Possible' as has the rationale for this change;

- This is in recognition of each of the partners in health and social care having given their commitment to addressing the content of the audit report and supporting the delivery of the action plan. Initiatives for tackling health

inequalities are now clearly evident throughout the strategic and commissioning plans.

Two additional controls have been added;

- The Health Equity Governance Board have agreed a mechanism with each of the partners for reporting all future actions and initiatives to ensure shared learning.
- A series of meetings between key partners has been ongoing to agree actions and the inclusion of strategic aims from the health equity strategy within strategic and commissioning plans. Specific initiatives now feature within these plans.

A new three month risk review date has been added.

3. ASSURANCE

The Committee is asked to note the following steps taken to implement the action plan;

- A Health Equity Governance Board, Chaired by NHS Tayside's Chief Executive, has been established and received reports on progress from each partner.
- Reports submitted to the Audit Committee on 15 September 2015, 27 January, 7 March and 22 April 2016 respectively to report on the progress towards completion of all recommendations within the audit report action plan.
- Strategic and Commissioning Plans have been agreed by each Integrated Joint Board (IJB). Health equity is clearly evident as a central pillar within each.
- NHS Tayside's Clinical Services Strategy (June 2015) includes health equity as an integral part of future direction. Implementation will progress through NHS Tayside's Strategic Transformation Programme.
- The Public Health Intelligence Department have developed a Tayside population health data set to be included within the refreshed strategy. Each IJB has been provided with detailed local data sets to assist the commissioning / planning process.
- The Director of Public Health is now a member of each IJB Board and each Community Planning Partnership. This will ensure public health leadership in health promotion, disease prevention and health equity in each forum.
- NHS Tayside Public Health senior staff have participated in a number of national events aimed specifically at identifying strategies to support health equity.
- Key performance measures are being developed and will be reported through each IJB and Directorate reporting structure. Health equity specific actions will also be reported to the Health Equity Governance Board.
- Mr David Crighton, Chairman, NHS Health Scotland met with Prof John Connell, NHS Tayside Chairman on the 16 March 2016 and welcomed the approach NHS Tayside is taking to addressing health equity.
- A review of the Health Equity Strategy led by the Public Health Directorate in collaboration with all stakeholders has been undertaken.
- Actions outlined within the Audit Report Action Plan will be completed on schedule.
- Public health colleagues have been participating in the development of a health equity strategy in Perth and Kinross IJB.
- Public health colleagues have been participating in the development of the Dundee Partnership Fairness Commission Action Plan 2017- 2020
- NHS Tayside Health Board held a board members development day on 29 September 2016 specifically aimed at the Public Health Annual Report and increasing awareness of the health equity agenda.

5. CONCLUSION

Work is progressing through the implementation of actions contained within the Internal Audit Action Plan and reported to the Health Equity Governance Board.

6. FURTHER ACTION

Public Health Directorate and partner organisation senior planning managers have agreed that the content of the strategy remains relevant therefore rewriting the strategy will be un-necessary. A paper will be finalised to support the original strategy, establish the current strategic context and describe how the strategy will contribute to the ongoing population health planning process.

The health equity strategy has been mapped against the nine strands of the health and wellbeing outcomes to indentify gaps and determine future direction. NHS Scotland's; 'A Fairer Healthier Scotland, Our Strategy (2012-2017) outlines an approach that identifies the fundamental causes of health inequalities as being an unequal distribution of income, power and wealth leading to poverty and marginalisation of individuals and groups. A diagram in their national publication describes in detail fundamental causes, wider environmental influences, individual experience and effects. It has been agreed this diagram will be adopted as the tool to assess future gaps against as it directs plans towards the themes of; 'undo', 'prevent', 'mitigate'. Senior planning officers and NHS Tayside's transformation programme lead officer are currently discussing how to measure service improvement plans against this tool.

7. REPORT SIGN OFF

Dr D Walker
Director of Public Health
NHS Tayside

Ms L McLay
Chief Executive
NHS Tayside

October 2016

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item 8.6.3

BOARD119/2016
Tayside NHS Board
27 October 2016

ASSURANCE REPORT SUSTAINABLE PRIMARY CARE SERVICES

1. STRATEGIC RISK

The Board Assurance Framework Strategic Risk Profile and individual risk reports from DATIX aims to identify the Strategic Risks that could impact on the delivery of NHS Tayside's objectives. The risk to which this report relates is the Sustainability of Primary Care. This risk recognises that failure to maintain sustainable Primary Care Services both in and out of hours in each locality across Tayside will result in a failure to achieve the 20/20 Vision, the National Clinical Strategy and local Primary Care Strategy resulting in patient being unable to access Primary Care Services

While there was evidence of service improvement work ongoing within both In and Out of Hours, there were concerns that the changes required or the work undertaken was not enough to build sustainable primary care services. A decision was taken to record it as a strategic risk in February.

2. CURRENT PERFORMANCE

Recent and current performance against this risk is highlighted in the table below.

Datix Ref	Risk Title	Lead Director	Inherent Risk Exposure	Feb 2016	June 2016	Aug 2016
353	Sustainable Primary Care Services	Chief Officer Angus HSCP	20 (5x4) Very High	12 (4x3) High	12 (4x3) High	12 (4x3) High

Following a meeting on 30th June 2016 a number of controls were agreed in order to support the sustainable delivery of Primary Care services.

- Weekly meetings via teleconference with HSCP/OOH/SAS to proactively manage the at risk days across both in and out of hours.
- Joint working between in and out of hours
- Ongoing recruitment to both in and out of hours
  - Successful recruitment to first five posts
- Primary Care sustainability Framework Developed
- Practices in difficulty monitoring process

3. ASSURANCE

The Board is asked to note the following steps taken to support the sustainable delivery of Primary Care services:

- Strategic and Commissioning Plans have been agreed by each Integration Joint Board (IJB). Primary and Community Care provision is clearly evident as a core deliverable in each.
- A clear reporting and governance structure has been agreed as part of the Angus Health and Social Care Partnership who host Primary Care (see Appendix 1).
- NHS Tayside Primary Care Strategy approved and implementation will progress through Tayside Primary Care Strategic Development and Transformational Board with representation from each of the Health and Social Care Partnerships.
- Reports submitted to Angus Executive Management Team Meetings, providing an update on Primary Care including Out of Hours.
- Engaged in all relevant national groups around Primary Care via Executive members of the Tayside Primary Care Strategic Development and Transformation Board.

4. REPORT DETAIL

Primary Care including Out of Hours have been experiencing significant challenges particularly in relation to availability of GPs to safely cover services. This is also reflected within the GP practices in Tayside whereby the availability of GPs is limited for locum cover and a reduction of GPs willing to take on partnerships within practices.

The OOH Service and Primary Care 2C practices have worked onerously to ensure adequate and safe cover however at times this has not been achieved. This is recognised locally within NHS Tayside and also nationally at Scottish Government level.

5. CONCLUSION

Given the current position within Primary Care the level of risk identified against delivery of the Sustainable Primary Care Services remains High. The traction over the forthcoming months on the implementation of the Primary Care Strategy and the National Transforming Programmes, together with the continued momentum and the strengthening of relationships across Primary Care that have been seen so far this year will all make inroads to improving the services.

6. FURTHER ACTION

Further actions will be discussed and agreed via the newly established Tayside Primary Care Strategic Development and Transformation Board (see Appendix 2).

7. REPORT SIGN OFF

Mrs V Irons
Chief Officer
Angus Health & Social Care Partnership

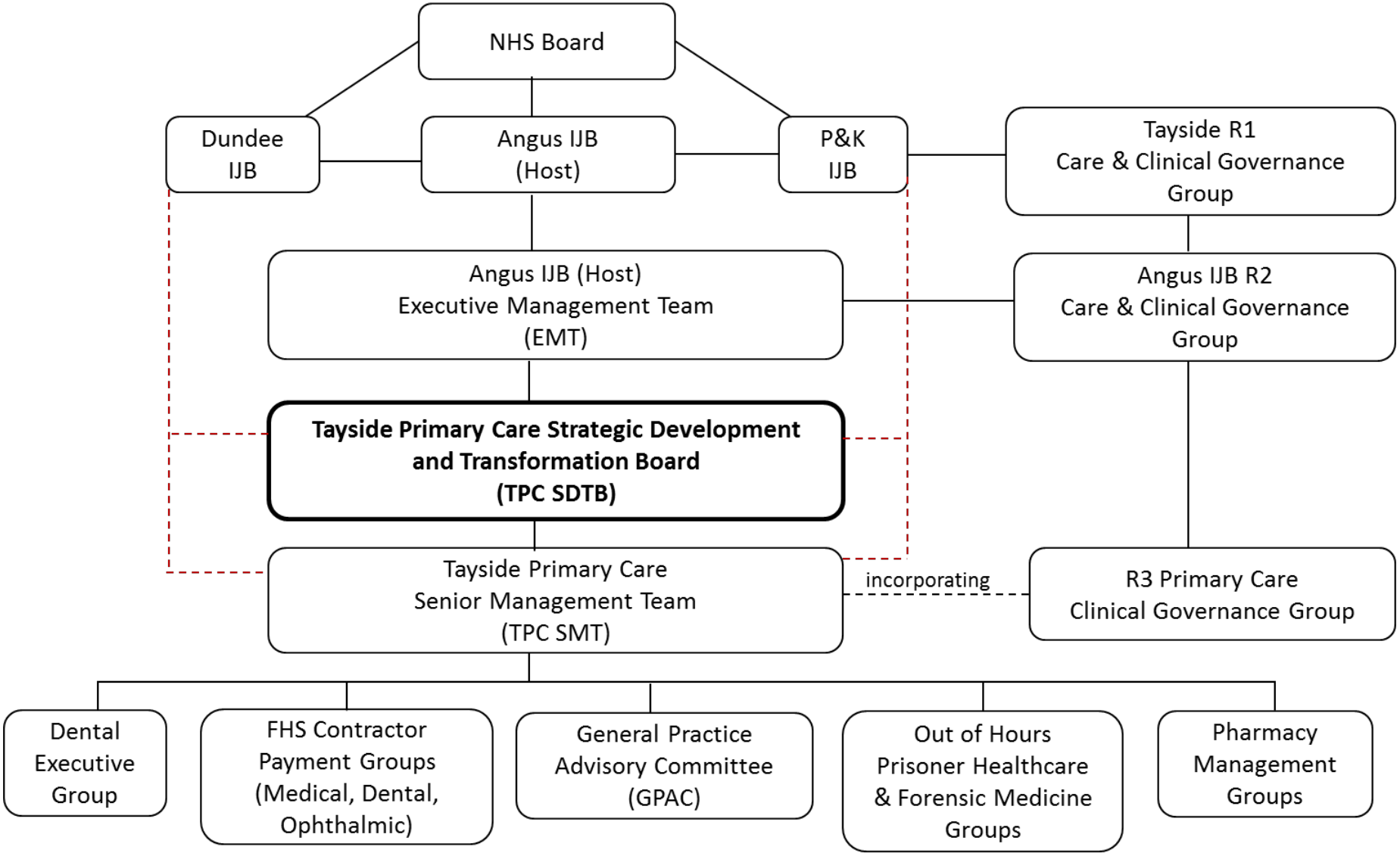
Ms L McLay
Chief Executive

October 2016

Appendix 1

V1 22.09.16

Primary Care Leadership Framework



* Note a range of additional operational groups underpin the existing Primary Care infrastructure outlined. There will be opportunity to review and consolidate arrangements.

Appendix 2

TERMS OF REFERENCE

TAYSIDE PRIMARY CARE STRATEGIC DEVELOPMENT AND TRANSFORMATION BOARD

1. Chairperson

The meeting will be chaired by Vicky Irons, Chief Officer, Angus Health and Social Care Partnership.

2. Administrative Support

Administrative support will be co-ordinated via Tayside Primary Care Services.

3. Purpose of the group

The purpose of the group is to provide overall strategic leadership of the transformation plans established across Primary Care including Contracted services (GMS, GDS, Pharmacy and Optometry), Out of Hours, Prison Healthcare and Forensic and Custody Healthcare.

4. Group Membership

- Chief Officer, Angus Health and Social Care Partnership
- Associate Medical Director Primary Care
- Associate Nurse Director Primary Care or Chief Nurse
- Clinical Director Dundee IJB
- Clinical Director Angus IJB
- Clinical Director Perth IJB
- Clinical Director Out of Hours
- Clinical Director General Dental Services
- Optometric Adviser
- Director of Pharmacy
- Member of the PFE Board (independent Pharmacy contractor)
- Chief Finance Officer Angus HSCP
- Senior Management Accountant Primary Care
- Capital Planning Representative
- E Health Representative
- General Manager Primary Care Services
- Head of PHC, OOH & FMS
- HR Lead
- IJB Lead for Primary Care Angus
- IJB Lead for Primary Care Dundee
- IJB Lead for Primary Care Perth and Kinross
- LMC and other Professional Body Reps.

Other key stakeholders will be invited as required

5. Frequency of Meetings

The meetings will be held will be monthly for a maximum of 2.5 hours.

6. Remit of the Group

The group will:

- Provide senior strategic leadership to ensure delivery of agreed work programme.
- Ensure ongoing monitoring of all elements of the work programme of Transforming Primary Care, including Transforming Urgent Care, Transforming Community Nursing and Prescription for Excellence.
- Provide financial governance for Primary Care Resources and in relation to the allocated funding to Tayside through Transforming Primary Care and Mental Health Fund, GP Recruitment and Retention Fund, Transforming Urgent Care.
- Ensure there is effective engagement with key stakeholders and other key programmes of work.
- Provide assurance to the IJBs that appropriate management and governance arrangements are in place in line with the hosting memorandum of understanding.
- Provide oversight of the Tayside Primary Care Senior Management Group and associated R3 Clinical and Care Governance arrangements to ensure that primary care services provided in IJB areas are underpinned by the 6 dimensions of quality :-
    - Patient Centred
    - Safe
    - Effective
    - Efficient
    - Equitable
    - Timely

7. Authority and Reporting Arrangements

The group will report to the Angus Integration Joint Board via the Angus Health and Social Care Partnership Executive Management Team.

Clinical and Care Governance arrangements will form part of the Tayside wide framework.

The group will update Health and Social Care Partnerships via the representative or nominated deputy.

8. Quorum

The group will be considered quorate when 6 members are present plus either Chief Officer or a nominated deputy.

9. Communication Strategy

Minutes of meetings submitted to group members.

Group members are responsible for sharing information with staff in their sphere of responsibility.

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

BOARD100/2016
Tayside NHS Board
27 October 2016

IMPACT OF WELFARE REFORM

1. SITUATION

Welfare Reform changes have been implemented by successive UK Governments, and some of the major changes are now taking effect. Whilst one aim of the reforms is to 'make work pay' it is widely recognised that for many people the result will be a reduction in income. The numbers of people affected and the nature of the health impacts make this a public health issue. The reforms are widely expected to have a detrimental impact on inequalities.
The Scottish Government commissioned a study[1] to explore the impact of ongoing welfare changes on a range of working-age households in Scotland. The study consisted of four sweeps of interviews (2013 – 2016). The report also sets out the major changes to welfare benefits, a link to it is given in references (below).
The purpose of this paper is to inform the Board of the findings of this study and emerging local evidence on the impacts of welfare reform.

2. BACKGROUND

Who is affected?

The changes mainly affect working age people who are in low paid employment or out of work, people with long-term health conditions and/or disabilities and those most disadvantaged within local communities. Benefit recipients including all working age council/housing association tenants who need help to pay their rent, and people in receipt of working tax credits are affected by welfare reform changes.

A number of NHS Tayside employees in low paid/part time positions are likely to be affected by the reforms.

In-work poverty is increasing. Although fewer households are completely work-less, many people are in jobs that do not provide adequate income. Falls in worklessness have been more than offset by falls in earnings. A study[2] reported by The Institute for Fiscal Studies (IFS) of the official household below-average income figures showed the problems of low income were increasingly associated with working households. Two in three children classified as living in "absolute poverty" now have at least one parent who is in work.

Local actions

A NHS Tayside Employability and Welfare Reform Forum has been established and meets regularly.
A local Action Plan[3] has been devised which captures ongoing activity and identifies further opportunities to mitigate the health impacts of welfare reforms (attached at Appendix 2).
Dedicated project management role established and filled from within current Directorate of Public Health staff complement. Role includes overseeing development, implementation and monitoring of NHST action plan.
A framework of indicators has been developed to monitor both the expected impacts of welfare reforms and of local actions. Collection of data is underway.

.

3. ASSESSMENT

The study[2] gives practical examples of the way in which welfare cuts have impacted negatively on some of the most vulnerable people in our communities, and recommends policy changes to mitigate.

The findings of the study show that people are not always aware of how benefits changes will affect them, or where to find advice and support. This reflects what has been reported anecdotally locally.
Local actions include:

- A LearnPro module for NHS Tayside staff to raise awareness, enable staff to identify people who may be experiencing impacts of benefits changes and signpost them appropriately to sources of advice and support.
- Welfare and Money Advice available in a range of healthcare settings including some GP surgeries, new Advice Shop located on the Ninewells concourse, CAB sessions for staff and In-work benefits sessions for staff provided jointly by Heathy Working Lives and local authority Welfare Rights teams.
- Development of NHS Tayside 'Money Worries' App, a free signposting app which includes contact details and live links to over 200 sources of advice and support. The app has been downloaded over 1,700 times since its launch in May 2015.
- A range of support and advice agencies have been promoted to staff via Staffnet, Spectra, payslip messages etc.
- A Welfare Reform Information Repository has been established accessible via Staffnet at http://staffnet.tayside.scot.nhs.uk/OurWebsites/WelfareReform/index.htm
- Local Authority partners have established Welfare reform webpages

The study recognised a gap in the provision of affordable childcare outside standard hours – this could affect NHS staff, particularly those who work shifts.

Study participants felt stigmatised by the welfare system itself, the media and some officials.
Local actions include:

- Learn-Pro module (as above)
- Poverty-sensitive training offered by partner organisations
- Training/awareness sessions for NHS Tayside Equality and Diversity Champions commenced June 2016

Better and more targeted employment support is needed for those deemed 'fit to work', particularly those with mental and physical health conditions which may fluctuate and affect their capacity to work. Opportunities may not be available for them in the labour market.

- There are a range of local employability initiatives which seek to address this.
- NHS Tayside Employability Services runs a suite of programmes promoting positive outcomes in employment, educational and training targeting people disadvantaged in the labour market.

The lack of stability and income security, particularly around reassessment of Employment Support Allowance and the transition from Disabled Living Allowance to Personal Independence Payments had a detrimental effect on the mental health of study participants:

> "It was a horrible process, it actually in terms of my progress it pushed me back, and I spent a lot of towards the end of last year really struggling with depression and anxiety, because of a lot of the things this process has brought up… Being made to relive [traumatic events] is horrific… It's a horrible, horrible assessment… It's harrowing."

Transitions were more difficult to cope with for those who were socially or geographically isolated, and the study report emphasised the importance of support agencies (many of them third sector organisations).

People furthest from the labour market due to serious health conditions were found to have needed considerable help with applications and appeals.
Those with health conditions which limit capability to work, or which are fluctuating or 'invisible' faced more benefit insecurity, and difficulties in finding work they were capable of undertaking. They also relied heavily on support agencies. In particular, people with mental health conditions felt that the benefits system did not take into account the way in which their condition affected their life. Those unable to work because of caring responsibilities, including lone parents, faced increasing pressure to seek work. Small increases in earnings may disbar from certain benefits (for example free school meals or clothing grants), having a net

negative impact on an already inadequate income. Carers also bear much of the stress of the impact of welfare reform on the benefits of those they care for.

Local actions to increase awareness of and access to sources of support and advice are outlined above.

- Healthy Working Lives with partners have developed Carers Information Packs for NHS Tayside staff who are carers

Local Indicators

The work on the local indicators framework is in its early stages. Some changes, e.g. Universal Credit and migration from Disabled Living Allowance to Personal Independence Payments are not yet fully implemented. Universal Credit has only recently been introduced to some claimant groups in Dundee, with the intention of rolling it out more widely. The full impact of the change to a single monthly payment to one adult in the household, and of additional conditionality for some claimants, has yet to be experienced locally.

Given the time lags inherent in some of the data sources, much of the data collected to date should be viewed as establishing a 'baseline' against which any future trends can be monitored. However there are increases in two indicators which could be as a result of Welfare Reform changes.

Referrals to Trussell Trust Foodbanks:

2015/16 referrals Angus 2,678 (27.5% increase on 2014/15),
Dundee 8,354 (18.5% increase)
Perth & Kinross 3, 434 (17% increase) (Source: The Trussell Trust)

There is a direct link between changes in welfare reform/benefit sanctions/delays in benefit payments and people needing to use foodbanks. In response to this need the Dundee Integration Joint Board has recommended " staff to have a presence at foodbanks and other venues used by disadvantaged people, particularly those [staff] working within health inequalities organisations such as the DHLI and Keep Well".

Crimes involving Domestic Abuse: there has been an increase in the number of cases heard at MARAC in all three areas of Tayside. In Dundee alone, in less than two years, these cases have gone from 10 per month to currently sitting at 16 per month. This cannot be directly linked to welfare reform changes, however, financial issues within households can be a causal factor.

- **RECOMMENDATIONS**

NHS Tayside should continue to consider the public health consequences of welfare benefit reform for our most vulnerable groups, in the context of the review of the Health Equity Strategy. Continuing support for a co-ordinated multi-agency approach to mitigating actions is needed, recognising that much valuable work is already being undertaken by NHS Tayside and partners.

Local indicators should continue to be monitored as Universal Credit is rolled out across Tayside, and any changes should inform future actions to mitigate the health impacts of welfare reform.

4. REPORT SIGN OFF

Dr D Gray
Senior Health Promotion Officer

Ms L McLay
Chief Executive

Dr D Walker
Director of Public Health

October 2016

References

1. Graham H, Egdell V, McQuaid R and Raeside R. 2016 The Impact of Welfare Reform in Scotland – Tracking Study. Scottish Government Social Research

Available at: http://www.gov.scot/Publications/2016/06/6672 accessed 18 July 2016

2. Belfield c, Cribb J, Hood A & Joyce R. 2016 Living standards, poverty and inequality in the UK 2016. Institute for Fiscal Studies

Available at http://www.ifs.org.uk/uploads/publications/comms/R117.pdf accessed 19 July 2016

Appendix 2

3. **NHS Tayside Welfare Reform Action Plan**

Welfare_Reform_-_Action_Plan_August20

See also: Scottish Public Health Network: *UK Welfare reform: Final Guidance for NHS Boards in Scotland on mitigating actions* April 2013

http://www.scotphn.net/pdf/2013_04_16_Final_Guidance_on_UK_Welfare_Reform.pdf

NHS TAYSIDE
MANAGING THE HEALTH IMPACT OF WELFARE REFORM
ACTION PLAN

NATIONAL PLAN SHORT-TERM OUTCOMES	NATIONAL PLAN EXAMPLES OF ACTIVITIES	NHS TAYSIDE ACTIONS	TAYSIDE DUNDEE ANGUS P & K	RESPONSIBLE PERSON	STATUS
1. We have identified our staff at risk of financial insecurity and provided appropriate services and support to maximise their income, reduce outgoings and increase their financial security.	Identify staff at risk of poverty and provide appropriate services and support	**CAB Money Advice Project** sessions offered to staff at Ninewells.		Jackie Bayne	Waiting information from CAB Director.
		Leaflet including signposting information re services providing advice on financial, employability, housing and legal matters, distributed with **Spectra** NHST staff magazine, 2013. To be repeated in form of comprehensive editorial piece in Spectra 2014/15 and messages reinforced via series of Vital Signs bulletins, information on payslips and Inbox weekly e-update.		Gaynyr Dickson, Communications Team/Aileen Tait	
		Welfare Reform/Benefits Advice Information Repository for staff to be launched and accessible via link on NHST Staffnet home page.		Communications Team/Alison Fannin	Launched October 2014 and promoted along with learnPro module from November onwards.
		Potential for establishing permanently-based, **multi-agency welfare benefits/financial advice centre** on main concourse, Ninewells Hospital under consideration. (Health Shops/Information Points at PRI and Whitehills HCCC and Links HC, Angus will also provide supporting literature/information.)		Aileen Tait / Derek Miller, DCC / Operations Directorate / Helen Brady, Health Shops Manager	Potential site identified – NHST Operations staff working with DCC Architects Dept on options appraisal exercise. Possible funding sources and staffing arrangements being explored.

		Angus Council Welfare Reform website and Angus Council Welfare Rights Service **Staff Advice Helpline** available to NHS staff in Angus – availability of these resources to be promoted via service managers.		Freda Stewart/Angus Council Welfare Rights Service	
		National charity**, Turn2us,** helps people in financial need gain access to welfare benefits, charitable grants and other financial help via an online service and a telephone helpline. Service to be promoted with NHST staff.		Aileen Tait/Gaynyr Dickson	
		Trade Union **UNISON** provides a range of **'There for You'** services for members, including **Debt Advice, Financial Assistance and Wellbeing Breaks**, as well as more general support and information, which can be accessed in times of need/crisis.		Allan Drummond	
	Provide classes for NHS staff in financial and IT literacy.	**Drop-in IT Awareness Sessions** to be held on main sites with support from IT staff. Publicity of sessions to be shared with managers to be cascaded to all staff. 50 PCs available in staff dining rooms across various sites for staff to access. Clear signage to be created to promote and encourage use of devices. Support packs and information to be created for staff.		E-Health Implementation and Development	
	Provide support for staff at work through provision of services and a supportive and enabling culture.	**Dundee City Council CONNECT team information stand/outreach activity**, Main Concourse, Level 7, Ninewells Hospital.		Alison Honeyman, Connect Team Leader, DCC	Service successfully trialled March 2014 – to be continued on monthly basis.

		NHST Healthy Working Lives team will look at identifying opportunities for progressing welfare reform awareness sessions within current training programme, exploring the potential for joint working with local authority welfare rights services and CAB.		Pat Davidson	DCC CONNECT Team/NHST HWL. Team delivering 1 x hour workshops on In-work Benefits for NHST staff in Dundee initially. HWL staff to receive training to roll out to other workplaces to ensure long-term sustainability. First sessions delivered Jan/Feb 2015 and further sessions at various sites in Dundee throughout May 2015. Local Authority Welfare Rights staff now also offering similar awareness sessions in Angus and P&K. Awareness sessions delivered from May 2015 through to January 2016 at sites in Tayside. These were delivered by Welfare Reform teams in Dundee, Angus and Perth and Kinross. The training for HWL team didn't proceed due to complexity of the issues and level of knowledge that would be required.
		NHST Department of Spiritual Care Provision for staff:		Gillian Munro, Head of Spiritual Care	Ongoing.

		• **Staff Support Listening and Signposting Service** based at Wellbeing Centre for staff, Royal Victoria Hospital, Dundee and available at other sites across Tayside. Access also via confidential helpline and email address – 24/7 on-call service. Self-referral plus via HR, Line Managers and staffside colleagues. • **Values-based reflective practice training** facilitated for staff in various disciplines.			
	Promote credit unions to NHS staff, contractors and partner organisations.	Information regarding **Credit Unions** in Dundee (Discovery Credit Union), Angus (Angus Credit Union) and P&K (P&K Credit Union), as well as NHS (Scotland and North England) Credit Union Ltd, to be distributed to NHS staff via various means as part of wider welfare reform/financial inclusion awareness raising/education programme. In particular, the facility for direct salary deductions for staff via Payroll for staff will be promoted.		Aileen Tait	Message on payslips January 2015 Credit Union info included in 'Money Advice for Staff' Vital Signs Bulletin, March 2015. To be repeated on a regular basis.
2. Good jobs/work opportunities available within NHS and partner organisations.	Provide employment/experience opportunities for populations affected by WR in all NHS departments.	**NHS Tayside Employability Services** has maintained and continues to develop its suite of programmes concerned with promoting positive outcomes in employment, education and training. This is in line with guiding principles based on close partnership working with external statutory and non-statutory organisations engaged in addressing employability issues across Tayside. All programmes are within the context of ongoing health and social care integration and reflect the Quality Strategy and NHS Tayside Aims, Vision and Values. **ACTIVITY SUMMARY 2014-2015**		Alison Smith	Activity Summary as described.

		Working with multi agency partners to develop employability based programmes in line with national, local and organisational drivers. • Working with partners across local councils, local FE Colleges and the voluntary and independent sectors to deliver vocational and qualification based programmes providing skills to enhance access to employment • Ensuring that programmes reflect the aims visions and values of health and social care within each locality • Ensuring ongoing review of programme content in line with locality profiles; reflecting national drivers, including the Scottish Credit and Qualifications Framework. • Working with NHS Tayside colleagues and local councils to review Employability delivery against a background of Welfare Reform **Employability Programmes** • Seven pre employment programmes were delivered across Tayside funded through the Department of Work and Pensions and Skills Development Scotland. These short courses are targeted at people experiencing joblessness • One 32 week course delivered via Dundee & Angus College leading to an SVQ 2 in Social Work and Health • One 32 week course delivered via Dundee & Angus College leading to an SVQ2 in Business & Administration • Talks are in progress to develop HNC			

		Business and Administration with placements across Angus **Young Peoples' Agenda** • Working with third sector partners to deliver 13 week work experience programmes for young people between 16-24 years • Partnership with Dundee City Council to support the NHS Tayside 'Looked After Young people programme' through identifying work experience placements • Discussion with Princes Trust around' Get into Care' **Public Engagement** • Continuing to engage with NHS Tayside Welfare Reform Group to inform employability programmes and support multi agency Welfare Reform activities • Working with Department of Work and Pensions to access work experience opportunities for people with barriers to work and positive destinations • Engaging with community based organisations to develop greater awareness of career prospects and structure within NHS Tayside and the wider care sector. **Health Care Support Workers** • Ensuring required support and guidance for staff around compliance with HCSW Induction Standards and Codes of Conduct. • Maintaining a robust recording system around HCSW compliance • Working with NHS Education for Scotland to			

		continue to develop meaningful delivery of the Codes of Conduct Champions • Ensure that all information around developments in Health Care Support Worker Standards is relayed timeously to senior HR managers. • Working closely with colleagues across NHS Tayside directorates to embed the values and principles of the Code of Conduct. **NATIONAL DRIVERS INFLUENCING NHS TAYSIDE EMPLOYABILITY SERVICES** - Health and Social Care Integration - Welfare Reform - 2020 Vision - Developing Scotland's Young Workforce - Creating a Fairer Scotland: Employability Support: A Discussion Paper - CEL23(2010) - Healthcare Support Workers Mandatory Induction Standards and Code of Conduct for Healthcare Support Workers and Mandatory Code of Practice for Employers of Health Care Support Workers			
		Healthy Working Lives, Health Works, the revised Healthy Working Lives strategy (Dec 2009) recognises the important role of 'good' work in maintaining health and wellbeing. HWL team continues to work with workplaces throughout Tayside encouraging and supporting uptake of the programme in order to provide 'good' work for staff.		Pat Davidson	Healthy Working Lives Programme continues but with a lesser priority (due to National funding cuts). However, this has allowed the "Workplace Team" to develop work according to local need. Team will priorities working with small/medium sized workplaces (employing less than 250 people)

					and addressing inequalities within other workplaces.
	Increase volunteering opportunities in the NHS and partners.	**NHST Volunteering Strategy** Investor in Volunteers Award 2011 Re-accredited 2014 Currently approx 1000 volunteers across NHST – important to ensure **quality** of support to increase capacity and improve service delivery rather than focus on **quantity**.		Tracey Passway, Clinical Governance and Risk Management Team Leader	
		NHS Spiritual Care Dept to develop volunteering opportunities in Staff Support Service – e.g. recruitment and training of volunteer listeners.		Gillian Munro, Head of Spiritual Care	
3. NHS workforce understand social determinants of health & health inequalities, and their role in reducing health inequalities.	Ensure consistency in corporate understanding and approach of NHS in relation to welfare system (inc leadership).	SBAR Report to NHST Chief Executive and Directors with recommendation that consideration be given to appointment of key leads for welfare reform at senior level within each Directorate to promote a common understanding of the impact of welfare reform and NHST's response role.		Drew Walker	
	Engage with colleagues in professional groups at all levels to ensure they understand the impact of WR and the impact on their service area.				
	Build allies/experts in each professional group to lead/champion this to their colleagues.	Using successful example of NHST Equality and Diversity Champion Scheme, possibility of recruiting and training welfare reform champions across the organisation to be explored.		Aileen Tait/Santosh Chima	Existing cohort of E&D champions to be supported to extend their signposting role to include welfare reform/financial issues

					via training/information sessions at Champions' Network Meetings throughout 2015/16.
	Promote holistic model of support which covers health, employment, housing, income, assets, stigma.				
	Ensure GPs are clear about their role and contractual obligations re supporting people to claim welfare benefits.	P&K **PLT Welfare Reform Session for GPs** and other primary care staff June 2014 P&K repeat session planned February 2015 Angus **PLT Welfare Reform session for GPs** and other primary care staff August 2014		Deborah Gray/Drew Walker Deborah Gray Rhona Guild/ Alex Duncan/Freda Stewart	Low attendance – to be repeated. 17 attendees – 86% of participants rated most aspects of the session as either good or excellent.
	Produce regular written and electronic updates on WR for NHS Board – formal papers and informal newsletters.	SBAR Report to NHST Executive Management Team **April 2013** Presentation of contents of EMT Report to Area Partnership Forum **May 2013** NHST Board paper submitted **July 2013** SBAR Report re WR and Employability Forum **October 2013** SBAR Update Report to NHST Directors		Drew Walker/Deborah Gray Deborah Gray Drew Walker/Deborah Gray Lucy Rennie Drew	Completed. Completed. Completed. Completed. Completed.

		Meeting **December 2014** SBAR Update Report to Dundee CHP Committee **October 2014** SBAR Update Report to Perth & Kinross CHP Committee **November 2014** SBAR Update Report to Angus CHP Committee **January 2015** Update to Area Partnership Forum **July 2016** SBAR update to NHS Tayside Board **Oct 2016**		Walker/Aileen Tait Lucy Rennie/Aileen Tait Aileen Tait/Alison Wood Aileen Tait/Freda Stewart Drew Walker/Deborah Gray Drew Walker/Deborah Gray	 Completed. Completed. Completed
4. NHS workforce have knowledge, skills and confidence to address social determinants of health & refer appropriately as part of routine practice.	Train frontline staff to respond to economic and social circumstances which affect health and wellbeing (health inequalities training).				
	Ensure staff are aware of agencies they can signpost patients to for welfare benefits advice and support (within and outwith NHS).	**Welfare Reform Learnpro e-learning module** being adapted for Tayside from previous version developed by NHS Lanarkshire and made available to all staff on NHST intranet site (Staffnet).		Jonathan Luckett/ Cathy Grieve	Launched and promoted November 2014.
		NHST Welfare Reform/Benefits Advice Information Repository includes information to support staff signposting patients.		Alison Fannin	Launched and promoted November 2014. Updated record management plan

					completed to reflect health and social care integration. To be reviewed on an annual basis.
		Mobile device App and associated promotional materials providing information to signpost individuals to appropriate local services being developed and piloted as a resource for staff to help them support patients/clients in financial crisis and link them to services.		Aileen Tait/Alison Smith	Development and Pilot Phase September 2014 – March 2015 final version live and formally launched and promotional materials distributed, May 2015. Content checked and updated March 2016. 1185 downloads in first year (to end April 2016). 500 downloads May – July 2016, of which 72% returning users. Poster presented at NHS Scotland Event June 2016 and accepted for Faculty of Public Health conference October 2016. At least 4 other Health Board areas have expressed interest in producing local adaptations of the App
		CAB/Angus Council producing **business cards to promote benefits advice and debt assistance services** – to be made available as a resource for all Health and Social Care Practitioners in Angus.		Freda Stewart	Distribution planned for mid-February 2015.

		'Benefits are Changing' information poster developed by Angus Council Welfare Rights Service to be distributed to GP practices, MIIUs, etc. in Angus to raise awareness of welfare reform for staff and the public.		Freda Stewart/Angus Primary Care Manager	
	Ensure staff have confidence and skills to raise issues of financial insecurity with patients.	**NHST Welfare Reform/Benefits Advice Information Repository** 'What staff can do' section encourages staff involved in direct care and treatment to include questions re 'money worries' as part of routine health assessments.		Alison Fannin	Available from November 2014.
	Use NHS Board's communications strategies to circulate information to staff about changes to welfare benefits.	**Welfare Reform Communications Plan** to be developed, reflecting a wide range of methods of communicating information to staff – e.g. launch of Learnpro module, article in SPECTRA, information on Staffnet and payslips.		Gaynyr Dickson, Communications Team/ Aileen Tait	Communications Plan produced July 2014. Article in Inbox 14/11/14 edition promoting Welfare Reform learnPro Module for staff and information repository. Info on Credit Unions on staff payslips, January 2015. 'Money Advice for Staff' Vital Signs Bulletin, March 2015.
	Provide specialist support for staff providing front line services (focusing on mental wellbeing) e.g. supervision models for staff.	**Healthy Working Lives** programme provides a range of workshops focussing on mental health and wellbeing. These are provided for workplaces throughout Tayside including NHS, Local authorities, Voluntary and Private Sector. Workshops include Mentally Healthy Workplace, Management Competencies and Resilience and Wellbeing and are open to anyone who manages staff. Participants are encouraged thereafter to promote use of MindSET online training package by their staff teams, in order to gain a basic understanding of mental health and		Pat Davidson/ Deborah Gray	From 1st April 2015 to 31st March 2016 following courses have been delivered: 7 x Mentally Healthy Workplace 6 x Resilience and Wellbeing 8 x Managers Competencies These have been attended by

		wellbeing.			representatives from a whole range of workplaces (including NHS Tayside). Team now encourage those attending to encourage their teams to access either the NHS Tayside "Live Positive" electronic learning tool (which can be accessed out-with the NHS) or the National Mentally Healthy Workplace elearning tool which again is accessible to all.
		Scotland's Mental Health First Aid 2xday training course is designed to provide participants with improved understanding of mental health problems, increased confidence to recognise problems in others and skills to support and signpost people to appropriate sources of help. Offered to members of the public and in workplaces across Tayside.		Deborah Gray	
		Equally Well, Dundee offer a 1xday **'Mind yer Heid'** training course for frontline staff and service managers in both statutory and voluntary sector organisations, a basic awareness session introducing skills that promote positive interactions and relationships between service users and providers to improve mental health and wellbeing. Participants receive guidance re accessing and navigating DCC 'My Wellbeing' website.		Sheila McMahon	**Update** From 2013 – 2016, 21 Mind Yer Heid Plus sessions were delivered to 288 frontline staff from a wide range of services and organisations. Evaluations demonstrated that all

					learning outcomes were being achieved, and follow-up with participants showed that people were putting their learning into practice. The My Wellbeing web pages continue to be updated and are well used, averaging between 350 – 400 hits per month.
		DCC **'My Wellbeing' website** provides source of social support for staff (including NHS staff) and members of the public.		Blair Finlay, DCC	
		NHST **Live Positive**, an online stress management tool, to be made available for managers and staff to access, either at home or in the workplace, as an aid to identifying and managing stress.			Launched October 2014.
	Build knowledge and skills in assets based approaches.				
5. Patients are actively supported to attend services (within and outwith NHS) to address their social and economic circumstances via agreed local pathways.	Work with partners to develop appropriate referral pathways and maintain them.	**Equally Well link workers and Sources of Support social prescribing team** refer to NHS services and partner agencies as appropriate via agreed referral pathways.		Sheila McMahon, DCC	**Update** In 2014, 211 patient referrals were made by GPs to SOS link workers and in 2015 the number was 209. During that period, patient engagement with the scheme increased from 78% to 81%. The number of

					services that link workers supported patients to access more than doubled from 48 in 2014 to 100 in 2015. Only 5 referrals were made to NHS services by link workers in 2014, increasing to 14 in 2015. This demonstrates that the vast majority of services that the link workers support patients to access are not health services, but those that deal with the wider influences on their health and wellbeing.
		P&K 'Well Connected' initiative promotes use of ALISS search engine as a community engagement tool to connect people to services.		Deborah Gray	Launched October 2014 as part of P&K Wellbeing Festival.
	Establish formal referral links between NHS and welfare rights agencies.	Development of **CATS** (Co-ordinated Advice Tracking System) **online referral system** in Dundee to allow access by NHS staff under discussion.		Derek Miller, DCC/Aileen Tait	
	Develop closer working relationships with employability partners.	**NHST Employability & Welfare Reform Forum** established June 2013 and meets bi-monthly – monitoring role re employability and welfare reform agenda.		Lucy Rennie Wendy Third	Welfare Reform Sub-group established June 2014.
	Broaden discharge planning (secondary care) to include social	Possibility of training for discharge planning teams from DCC Financial Inclusion Service to be explored.		Derek Miller, DCC/Aileen Tait	

	consideration and social prescribing/referral as required (e.g. via Well Connected service in Lanarkshire).				
6. Assessment and management processes include social and economic circumstances.	Review and standardise routine health assessments to routinely include financial questions and other relevant social circumstances (e.g. gender based violence).	**Keep Well** health check questionnaire includes questions on Social History, Employment and Finances with opportunities for referral/signposting to employment and benefits review/money advice services.		Shona Hyman	These elements are routinely asked as part of the health check, with advice and support to access help where required. Across Tayside 1260 individuals have had a Keep Well health check in April15- March16 from the 3 teams who focus on “vulnerable groups” ie homeless, substance misuse, offenders, and carers, as well as those who live in areas within 20% most deprived postcodes according to SIMD . The age range for these groups has been reduced so that more people are benefitting. General practices also continue to deliver KW but we are uncertain on final numbers. It is estimated that around 2500 people in total will have had an assessment that includes these aspects.

		Glen Isla Project supports females across Angus referred by the courts on **Community Payback Orders**, assessing them for referral to appropriate health services. Assessment process includes questions regarding finances and social circumstances, e.g. if subject to gender-based violence, to ensure access to appropriate services/support.		Freda Stewart	
	Influence a more accurate assessment of ability to work.	**PLT sessions on Welfare Reform** for **GPs** in P&K and Angus to include opportunities for discussion re how their role in the ESA/PIP appeals process might influence accuracy of outcome.		Deborah Gray Alex Duncan/ Freda Stewart	
	Implement evidence-based vocational rehabilitation approach, targeting those affected by WR.	Wide range of Vocational Rehabilitation services/initiatives led by the Allied Health Professionals		Shelagh Creegan	

		Working Health Services is a vocational rehabilitation service for employees in small and medium sized businesses (less than 250 staff) and people who are self employed, offering free, rapid and confidential access to specialist work health professionals. Services available include physiotherapy, counselling, mental health specialists, case management (including return to work support) and occupational therapy. The aim is to enable clients with health problems to remain in work or to return to work following a period of sickness absence. Examples of the work of the service include: • Working in partnership with Healthy Working Lives to develop and deliver tailored training for employers. • Routinely signposting to support organisations within Tayside for help and advice on employment law, welfare reform and money advice. • Developing a Vocational Rehabilitation Learnpro module for AHPs in the mental health sector to trial and then roll out to all AHP staff. • Trialling a case management stress pilot for Dundee CHP staff, to support staff off work or at risk of going off work due to stress. • Developing a community of practice within Tayside for staff to share good practice around VR work in Tayside.		Cat Moulton	Majority of staff accessing pilot returned to work or remained at work –discussions ongoing with TCOE re future rollout.
7. Capacity and capability in NHS and partners is adequate to respond to demand	Engage with health and social care and local authorities to develop the local plan.	Established links to all three **Local Authority/Health and Community Care Partnership** areas via CHP staff who report into NHST Employability and Welfare Reform Forum.		Lucy Rennie Alison Wood Freda Stewart	

	Ensure NHS representation on local authority WR strategic planning groups (or equiv).	NHS Tayside representatives attend employability partnership groups and Welfare Reform planning groups in each of the three areas of Tayside: **Angus Employability Partnership** **Angus Financial Inclusion Strategy Group** **Dundee Employability Partnership Group** **Dundee Welfare Reform Group** **Perth & Kinross Employability Network** **P&K Joint Welfare Reform Steering Group** Representatives provide feedback to NHST Welfare Reform and Employability Forum	 Freda Stewart Lucy Rennie Chris Lamont/Deborah Gray		
	Work in partnership at Community Planning level and within the developing health and social care arrangements to ensure support to those at risk of poverty or ill health.	**Dundee CHP** links to **Dundee Community Planning Partnership** via Healthy Dundee and is a partner in Health and Social Care Integration Support Group.		Lucy Rennie	
		SBAR Update Reports to all 3 CHP Committees to contain recommendations re linking Welfare Reform agenda to Community Planning and Health and Social Care Integration structures and services.		Aileen Tait	
	Build pathways to advice services (inc 3rd sector), build their capacity and help them cope with increased demand.	**Department of Spiritual Care Listening Service**, 'Do you need to talk?' to be provided in GP practices, hospital clinic settings and community support groups (e.g. Hearing Voices Network, Drug Rehab) to increase capacity to cope with demand on services.		Gillian Munro, Head of Spiritual Care	

		NHST Innovation Fund Cash4Communities Project plays a vital role in supporting local people to improve the health, wellbeing and resilience of their own communities by funding sustainable projects across Tayside. This involves working in partnership with disadvantaged communities on a co-production basis to build capacity to address health inequalities, promote quality of life and overall health and wellbeing, create a stronger sense of community and improve social relationships.		Richard McIntosh, Community Capacity Building Officer	Funding support for advice services channelled via the 3 Tayside 3rd sector interface organisations – Dundee Voluntary Action, Volunteer Action Angus and P & K Association of Voluntary Services.
	Establish welfare rights workers in GP practices and other PC facilities in areas of deprivation	Provision of weekly **outreach sessions** at The Crescent Community Hub, Whitfield and Lochee Medical Centre by **DCC CONNECT Team**.		Alison Honeyman, CONNECT Team Leader, DCC	Negotiation underway re extending service to other Dundee practices.
		Equally Well Social Prescribers based in GP Practices in Dundee link patients to welfare rights/money advice services.		Sheila McMahon	4 Social Prescriber Link Workers currently based in 5 GP Practices (Mill, Fintry Mill, Erskine, Maryfield, Whitfield). **Update** In 2015, 30% of patients engaging with the link workers set goals relating to their financial circumstances, and these patients were supported to access a range of financial inclusion services to address their needs. A pilot scheme to fast track patients to money advice was implemented in

					2015/16, which saw a cohort of 25 patients from one medical centre have their financial needs and money worries addressed more quickly than before.
		Welfare Rights Workers to be co-located with primary care staff in **GP practices** in **Dundee,** offering regular weekly advice sessions.		Craig Mason, DCC Welfare Rights Service	Now working out of 4 GP practices across the city with a view to extending this service.
		Input from **Welfare Rights services** to **GP practices** currently under consideration in Angus and Perth & Kinross.			
	Ensure that good welfare rights advice and other social support services, including fuel and food poverty initiatives are readily available and accessible.	As part of P&K Partnership FP Action Plan – Fuel Poverty Steering Group – multi-agency **fuel poverty training** is offered on regular basis. Awareness of this is raised with NHS staff.		Chris Lamont, P&K CHP	
		Dundee City Council Fairness Strategy for Challenging Poverty and Promoting Inclusion in Dundee, highlights **Fuel Poverty** as a key area for targeting of services.		Blair Finlay, DCC	
		Free independent **advice on energy efficiency** and saving money on fuel bills is available through: **Dundee Energy Efficiency Advice Project** **Perth & Kinross Energy Efficiency Team** **Angus Heat in partnership with SCARF**			

		Poverty relief charity, **Turn2us**, works in partnership with energy company SSE to provide support for low income and vulnerable households in Scotland to reduce energy bills. Service to be promoted with NHST staff and patients.		Aileen Tait/Gaynyr Dickson	
		Trade Union **UNISON**'s 'There for You' range of support services for members includes **'Help with Energy Costs'** service.		Allan Drummond	
		Foodbank provision across Tayside to be supported and widely publicised by NHST via a variety of means such as Welfare Reform information repository, awareness-raising/training for staff and mobile device App, and also by all partner organisations.		Aileen Tait	
		UK-wide **Healthy Start** scheme promoted and administered by NHS Tayside Public Health Nutrition Service. Provides vouchers for the purchase of milk, fruit & veg and vitamins for pregnant women and families with children under 4 years and in receipt of certain benefits.		Carol Barnett, Maternal & Infant Nutrition Programme Manager	Uptake of Healthy Start across Tayside remains around 75% despite proactive promotion of the scheme through media opportunities and training programmes. Distribution of Healthy Start vitamins is now coordinated through Public Health and all pregnant and breastfeeding women are receiving free vitamins from their midwife. Health Visitors are supplying childrens vitamins. The HV does not have contact with families to provide a constant supply of the

					vitamins so a solution to providing easy access to further supplies of vitamins has yet to be established.
8. Reduced stigmatisation of benefit recipients.	Develop social marketing campaigns for staff and population as a whole, and training for staff in NHS and LAs to dispel myths and prejudices about poverty and welfare benefits claimants.	**Connect Team Info stand/outreach work** at Ninewells Hospital addresses issue of stigma during staff/public engagement.		Alison Honeyman, DCC	Regular monthly advice/info sessions at Ninewells.
		All **Communication Plan** and staff **training/awareness raising** activities include **anti-stigma** educational element.		Aileen Tait	
		Development of **Public Health** 'See Me' style **anti-stigma campaign materials** in relation to welfare benefits claimants to be explored.		Aileen Tait/Alistair McGillivray	
9. Local Health Inequality Impact Assessments address income inequalities, poverty and stigma.	Update EQIAs to include income inequality, poverty and stigma.	**NHST Equality Impact Assessment Policy**, February 2014 covers **4 key areas** of impact for equality groups and people with protected characteristics – **Equality & Diversity, Human Rights, Health Inequalities** and **Financial Decisions.**		Santosh Chima, Diversity and Inclusion Manager	Policy Review Date February 2016.
	Through EQIA, NHS organisations regularly review contracts of employment, pay rates and HR policies (inc working hours, redeployment and security of contract) for staff (health, social care and contractors).	Awaiting input from HR representative.		Jackie Bayne	
10. NHS is monitoring the impact of WR	Incorporate NHS response to potential				

on our population and redesigning services to respond to demand.	risks to health and health inequalities into health plans and ensure it is referred to in accountability reviews across all planning frameworks.				
	Monitor the impact of WR on population and services using this agreed plan and respond to increased demand for/use of services.	Impact on population to be monitored using **ScotPHO Community profiles** and **locally available data.**		Aileen Tait/Deborah Gray/Phyllis Easton	Welfare Reform Indicators available – work by Russell Goldsmith.
11. NHS builds understanding and evidence about risks to health and inequalities and actively uses this to inform service planning and developments.	Develop a monitoring plan that uses different types of intelligence to help build understanding about the impact (positive and negative) of WR in Scotland on population health, health inequalities and services.	Robust **evaluation framework** to be developed and potential for use of ScotPHO Community Health Profiles, as well as locally available data, to be explored.		Aileen Tait/Deborah Gray/Phyllis Easton	
	Gather information on GPs and other staff to provide evidence for WR applications and appeals.				
	Use feedback and available intelligence on system impacts to make adjustments (e.g. Scottish Welfare Fund).				
	NHS identifies and acts on its role in responding				

	to consultation (as critical advisor).				
	Ensure progressive health promoting procurement strategies and service level agreements.	In Perth and Kinross will be taken forward via the joint commissioning process with P&K Council.		Alison Wood	

Item 9.2

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

BOARD126/2016
Tayside NHS Board
27 October 2016

ESTABLISHING INTEGRATED MANAGEMENT AND DEVELOPMENT ARRANGEMENTS FOR PRIMARY CARE IN TAYSIDE

1. SUMMARY

The development of future sustainable Primary Care Services in NHS Tayside are essential to the effective and efficient delivery of health and care services. This progress report sets out arrangements for a new leadership framework.

2. BACKGROUND

Following the establishment of the Angus Integration Authority, the Chief Officer has been working with stakeholders across NHS Tayside to review and revise the leadership framework for the management and development of primary care services. The paper at Appendix 1 sets out the revised arrangements which will be established in November 2016. This will see the establishment of a refreshed Senior Management Group, and also a Strategic Management and Transformation Board. Governing arrangements will be established as part of the IJB infrastructure with an R3 Care and Clinical Governance Group for Primary Care, and reporting lines flowing through current hosting arrangements as set out in the Memorandum of Understanding.

3. ACTION / RECOMMENDATIONS

Board members are asked to:

(i) Note the revised arrangements

(ii) Note that further organisational development support will be required to underpin refreshed arrangements

(iii) Note the membership and support of the Tayside Primary Care Strategic Management and Transformation Board, and whether any amendments or additions are required

Mrs V Irons
Chief Officer
Angus Health & Social Care Partnership

Ms L McLay
Chief Executive
NHS Tayside

October 2016

APPENDIX 1

Establishing Integrated Management and Development Arrangements for Primary Care in Tayside.

Background Information

The development of future sustainable Primary Care Services in NHS Tayside are essential to the effective and efficient delivery of health and care services.

A range of strategies are currently outlined across the four primary care groups. Management arrangements reflect those in place prior to the establishment of HSCPs, and the delegated responsibilities now in place for the three Tayside Integration Joint Boards (IJBs).

Part of the process of establishing new arrangements under HSCP arrangements presents an opportunity to review current management arrangements to develop a coordinated framework across Tayside, and the opportunity to establish a refreshed approach to overseeing the transformation required in line with Primary Care Strategies. A hosting arrangement has been agreed, which will establish Angus IJB as the "host" in terms of overseeing the strategic development of primary care services. Angus will also host the management of contractor services, out of hours, forensic medicine, community pharmacy and the development of pan Tayside management expertise which will underpin the local primary care leadership of directly managed GMS in each IJB area.

This paper sets out arrangements for a new leadership framework.

New Leadership arrangements

The revised arrangements set out are based on a series of discussions and evaluation of the current framework in NHS Tayside. The review and conversations held have highlighted an opportunity to consolidate our approach, and create more integration and efficacy.

The refreshed organisational arrangements will support the spirit of the reforms, IJB arrangements, cluster arrangements and local leadership. They will release professional lead roles to focus on the leadership required and to develop robust clinical and care governance arrangements and ensure that managerial functions are supported by the relevant management leads. The new framework will ensure there is clarity of role and accountabilities as part of a network without reverting to a centralist approach. The development and delivery of primary care is integral to the delegated and integrated approach of each IJB. The hosted Tayside arrangements will be established to facilitate the delivery of joint strategic aims including primary care transformation plans, directly manage a range of primary care services as set out in the Integration scheme, host the management of the primary care contractor services on behalf of the NHS Board through the Chief Officer, and establish core expertise in practice management of 2c arrangements. These are set out to support local leadership and not replace the interest and responsibilities of each IJB for the management and development of primary care as part of the wider community approach to integrate services.

The new arrangements bring together the Tayside wide professional lead roles, with Tayside accountable managers (including supporting service leads in HR, Finance and Estates), local IJB primary care management leads, and Clinical Directors.

The success of revised arrangements will be based on the refreshed efforts and collaboration of all of those engaged.

The revised arrangements set out in Appendix A establish an integrated approach to the management and governance arrangements for Primary Care Services. These are based on the development of a coordinated approach across primary care contractor groups and each of the IJBs.

The revised arrangements will see the establishment of a **Tayside Primary Care Strategic Management and Transformation Board** (TPC SMTB). This will be underpinned by a coordinated and integrated approach of the **Tayside Primary Care Senior Management Group** (TPC SMG).

TPC SMTB will be chaired by the Chief Officer of Angus IJB and will meet monthly. The purpose of the Board is to provide overall strategic leadership of the transformation plans established across Primary Care including Contracted services (GMS, GDS, Pharmacy and Optometry), Out of Hours, Prison Healthcare and Forensic and Custody Healthcare.

TPC SMG will be co-created by the Tayside Primary Care Management Leads (Jill Galloway and Jane Haskett), and IJB Management Leads to establish a framework of integrated management arrangements to ensure:

- services are delivered in a safe and effective way (through the development of R3 care and clinical governance group – chaired by the Associate Medical Director for Primary Care).
- effective use of all resources to improve efficiency and productivity and effective management of the financial resources available.
- implementation of the Primary Care Strategy and Transformation programmes across all contractor groups, including the coordination and monitoring of recent primary care development programmes aligned with national funding.

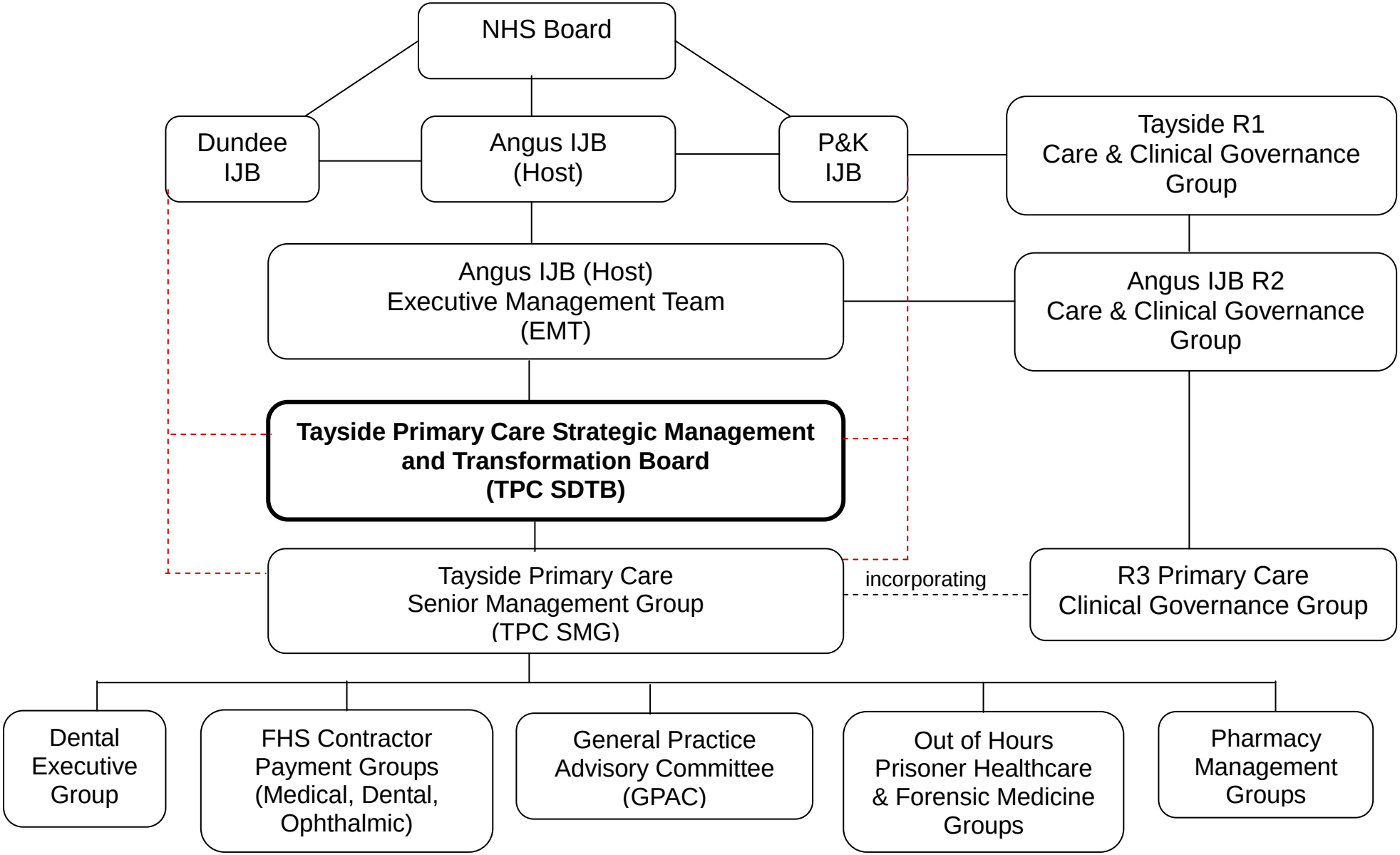
The TMC SMT will be underpinned by a range of existing groups overseeing more detailed arrangements. These would also benefit from some further review.

More details of membership and the draft role and remit for revised arrangements are available in Appendix B.

Vicky Irons
Chief Officer – Angus HSCP
3 October 2016

Primary Care Leadership Framework

V1 22.09.16



Appendix B

TERMS OF REFERENCE

TAYSIDE PRIMARY CARE STRATEGIC DEVELOPMENT AND TRANSFORMATION BOARD

1. Chairperson

The meeting will be chaired by Vicky Irons, Chief Officer, Angus Health and Social Care Partnership.

2. Administrative Support

Administrative support will be co-ordinated via Tayside Primary Care Services.

3. Purpose of the group

The purpose of the group is to provide overall strategic leadership of the transformation plans established across Primary Care including Contracted services (GMS, GDS, Pharmacy and Optometry), Out of Hours, Prison Healthcare and Forensic and Custody Healthcare.

4. Group Membership

- Chief Officer, Angus Health and Social Care Partnership
- Associate Medical Director Primary Care
- Chief Nurse
- Clinical Director Dundee IJB
- Clinical Director Angus IJB
- Clinical Director Perth IJB
- Clinical Director Out of Hours
- Clinical Director General Dental Services
- Optometric Adviser
- Director of Pharmacy
- Director of AHPs
- Member of the PFE Board (independent Pharmacy contractor)
- Chief Finance Officer Angus HSCP
- Senior Management Accountant Primary Care
- Capital Planning Representative
- E Health Representative
- General Manager Primary Care Services
- Head of PHC, OOH & FMS
- HR Lead
- IJB Lead for Primary Care Angus
- IJB Lead for Primary Care Dundee
- IJB Lead for Primary Care Perth and Kinross
- G.P. Sub and other Professional Body Reps.

Other key stakeholders will be invited as required

5. Frequency of Meetings

The meetings will be held will be monthly for a maximum of 2.5 hours.

6. Remit of the Group

The group will:

- Provide senior strategic leadership to ensure delivery of agreed work programme.
- Ensure ongoing monitoring of all elements of the work programme of Transforming Primary Care, including Transforming Urgent Care, Transforming Community Nursing and Prescription for Excellence.
- Provide financial governance for Primary Care Resources and in relation to the allocated funding to Tayside through Transforming Primary Care and Mental Health Fund, GP Recruitment and Retention Fund, Transforming Urgent Care.
- Ensure there is effective engagement with key stakeholders and other key programmes of work.
- Provide assurance to the IJBs that appropriate management and governance arrangements are in place in line with the hosting memorandum of understanding.
- Provide oversight of the Tayside Primary Care Senior Management Group and associated R3 Clinical and Care Governance arrangements to ensure that primary care services provided in IJB areas are underpinned by the 6 dimensions of quality :-
    - Patient Centred
    - Safe
    - Effective
    - Efficient
    - Equitable
    - Timely

7. Authority and Reporting Arrangements

The group will report to the Angus Integration Joint Board via the Angus Health and Social Care Partnership Executive Management Team.

Clinical and Care Governance arrangements will form part of the Tayside wide framework.

The group will update Health and Social Care Partnerships via the representative or nominated deputy.

8. Quorum

The group will be considered quorate when 6 members are present plus either Chief Officer or a nominated deputy.

9. Communication Strategy

Minutes of meetings submitted to group members.

Group members are responsible for sharing information with staff in their sphere of responsibility.

TAYSIDE PRIMARY CARE SENIOR MANAGEMENT GROUP

1. Management arrangements will be co-created by Jillian Galloway, Head of OOH, PHC &FMS and Jane Haskett, General Manager Primary Care Services with the relevant primary care management leads in each IJB.

2. Administrative Support

Administrative support will be co-ordinated via Tayside Primary Care Services.

3. Purpose of the group

Management arrangements will be established to ensure:

- services are delivered in a safe and effective way (through the development of R3 care and clinical governance group – chaired by the Associate Medical Director for Primary Care).
- effective use of all resources to improve efficiency and productivity and effective management of the financial resources available.
- implementation of the Primary Care Strategy and Transformation programmes across all contractor groups, including the coordination and monitoring or recent primary care development programmes aligned with national funding.

4. Group Membership

To be determined, with a minimum requirement of:

- Head of PHC, OOH & FMS (co-chair)
- General Manager Primary Care Services (co-chair)
- Associate Medical Director Primary Care
- Chief Nurse
- Associate Director of Pharmacy
- Primary Care Management Lead Dundee
- Primary Care Management Lead Angus
- Primary Care Management Lead Perth
- Finance Representative
- Project and Project Management aligned to key change programmes

5. Frequency of Meetings

As required

6. Remit of the Group

The group will:

- Provide senior operational and clinical leadership to ensure delivery of agreed work programme.
- Ensure ongoing monitoring of all elements of the work programme demonstrating accountability for delivery and continuous improvement care services.

- Ensure there is effective engagement with key stakeholders and sub groups.
- Incorporate the creation of R3 Care and Clinical Governance Arrangements to ensure that the services administered and delivered are underpinned by the 6 dimensions of quality:-

  Patient Centred
  Safe
  Effective
  Efficient
  Equitable
  Timely

7. Authority and Reporting Arrangement

The group will report to Tayside Primary Care Strategic Management and Transformation Board via the group chair person or nominated deputy.

8. Quorum

The group will be considered quorate when **5** members are present.

9. Communication Strategy

Minutes of meetings submitted to group members.

Group members are responsible for sharing information with staff in their sphere of responsibility.

Attendance Record **NHS Tayside**

Tayside NHS Board 1 April 2016– 31 March 2017

Name	Designation	21 April 2016	12 May 2016	26 May 2016	23 June 2016	25 Aug 2016	27 Sep 2016			
Member										
Mrs P Campbell	Non Executive Member	Present	Present	Present	N/A	N/A	N/A			
Prof J Connell	Chairman	Present	Present	Present	Present	Present	Present			
Mrs G Costello	Nurse Director	Present	Apologies	Present	Present	Present	Apologies			
Dr A Cowie	Non Executive Member	Present	Present	Present	Present	Present	Apologies			
Mr D Cross	Non Executive Member	Present	Present	Present	Present	Present	Present			
Councillor D Doogan	Non Executive Member	Present	Apologies	Apologies	Present	Present	Present			
Mrs L Dunion	Non Executive Member	Present	Present	Present	Present	Present	Apologies			
Mrs J Golden	Non Executive Member	Present	Present	Present	Present	Present	Present			
Mr S Hay	Non Executive Member	Present	Present	Present	Present	Present	Apologies			
Mr M Hussain	Non Executive Member	Present	Present	Present	Present	Present	Present			
Councillor K Lynn	Non Executive Member	Apologies	Apologies	Present	Present	Present	Present			
Councillor G Middleton	Non Executive Member	Present	Present	Present	Present	Present	Apologies			
Ms L McLay	Chief Executive	Present	Present	Present	Present	Present	Apologies			
Mr H Robertson	Non Executive Member	Present	Present	Present	Present	Present	Apologies			
Mrs A Rogers	Non Executive Member	Present	Present	Present	Present	Present	Present			
Dr A Russell	Executive Member	Present	Present	Present	Present	Present	Apologies			

Tayside NHS Board 1 April 2016– 31 March 2017

Prof M Smith	Non Executive Member	Present	Apologies	Present	Present	Present	Apologies			
Mrs S Tunstall-James	Non Executive Member	Present	Present	Present	Present	Present	Present			
Dr D Walker	Executive Member	Apologies	Apologies	Apologies	Present	Present	Apologies			
Attendees										
Mrs J Alexander	Partnership Representative	Present	Apologies	Present	Apologies	Present	Apologies			
Mr L Bedford	Interim Director of Finance	Present	Present	Present	Present	Present	Present			
Dr A Cook	Medical Director – Operational Services	Present	Apologies	Apologies	Apologies	Present	Apologies			
Mr G Doherty	Director of Human Resources	Present	Present	Present	Present	Present	Present			
Ms M Dunning	Board Secretary	Present	Present	Present	Present	Apologies	Present			
Mr T Gaskin	Chief Internal Auditor	Present	Apologies	Apologies	Apologies	Present	Apologies			

Minute NHS Tayside

TAYSIDE NHS BOARD
AUDIT COMMITTEE - OPEN BUSINESS

Minute of the meeting of Tayside NHS Board Audit Committee held at 9.45 a.m. on **Tuesday 21 June 2016** in the Board Room, Conference Suite, King's Cross, Dundee

Present:
Mr D Cross, OBE, Non Executive Member, Tayside NHS Board
Mrs J Golden, Non Executive Member, Tayside NHS Board
Mr S Hay, Non Executive member, Tayside NHS Board (Chair)
Mr M Hussain, Non Executive Member, Tayside NHS Board
Councillor G Middleton, Non Executive Member, Tayside NHS Board

Chair, Chief Executives and Senior Officers
Mr L Bedford, Interim Director of Finance, NHS Tayside
Prof J Connell, Chair, Tayside NHS Board
Mr G Doherty, Director of Human Resources, NHS Tayside
Mr R MacKinnon, Associate Director of Finance - Financial Services & Governance/FLO, NHS Tayside
Ms L McLay, Chief Executive, NHS Tayside

External Auditors
Ms G Collin, Senior Manager, PricewaterhouseCoopers
Mr K Wilson, Senior Manager, PricewaterhouseCoopers

Internal Audit – FTF Audit and Management Services
Mr T Gaskin, Chief Internal Auditor, FTF Audit and Management Services
Mrs J Lyall, Acting Regional Audit Manager, FTF Audit and Management Services

Other Attendees
Miss W Aitchison, Endowment Accountant, NHS Tayside
Mr P Crichton, External Auditor, MMG Archbold (Item 5)
Ms M Dunning, Board Secretary, NHS Tayside
Mr G Finnie, Financial Accountant, NHS Tayside
Miss J Flood, Financial Accountant, NHS Tayside
Mrs F Gibson, Head of Financial Services, NHS Tayside
Mrs L Green, Committee Support Officer, NHS Tayside
Miss D Howey, Head of Committee Administration, NHS Tayside
Mr D Mills, Representative Area Clinical Forum, NHS Tayside
Mr D Taylor, External Auditor, Henderson Loggie (Item 6)

Apologies
Councillor D Doogan, Non Executive Member, Tayside NHS Board
Ms L Dunion, Non Executive Member, Tayside NHS Board
Mrs H Walker, Risk Manager, NHS Tayside

Mr S Hay in the Chair

ACTION

1. WELCOME

The Committee moved into open business.

2. APOLOGIES

The apologies were noted as above.

3. DECLARATION OF INTERESTS

Mr Hay wished to note his thanks to Mrs Penny Campbell for her valuable and helpful contributions to the Committee prior to her resignation.

4. MINUTE OF PREVIOUS MEETING

4.1 Minute of the Audit Committee Minute – 5 May 2016

The Audit Committee Minute of the meeting held on 5 May 2016 was approved on the motion of Mr D Cross and seconded by Mr M Hussain.

4.2 Action Points Update

Mr MacKinnon spoke to the Action Points Update.

Recording Equipment – It was noted this matter was progressing and discussions with staff side colleagues were ongoing.

External Review of all Mental Health Sites – It was noted a report would be submitted to a future Committee meeting following review by the Principal Architect.

Work Plan Progress Report – It was noted this was an Agenda item.

Workshop for Non Executive Members – It was noted the facilitation of a short workshop for Non Executive Members to address issues regarding access to NHS Mail, Staffnet and Network Devices from various devices had been scheduled for 22 September 2016 and further details would be circulated in due course.

Progress on Internal Audit Report T21/14 Medical Instrumentation and Devices – It was noted that the Head of Instrumentation post had been filled and an update would be given to the Committee at its meeting on 1 September 2016.

Risk Manager attendance at Strategic Risk Management (SRMG) meetings – It was noted Mr Hay would consult with the Chief Executive regarding Risk Managers attendance at SRMG following this Committee meeting.

HSCI Governance Presentation – It was noted the HSCI Governance presentation would be given to Tayside NHS Board at its December 2016 meeting.

NHS Scotland Overview Report and Checklist – It was noted a Board Development Session had been arranged for 22 September 2016.

Adverse Events Management Policy – It was noted this would be an Agenda item at the 1 September 2016 meeting.

The Committee noted all completed actions.

4.3 Work Plan Update

Mr MacKinnon advised the Committee that the Work Plan had been updated to include the Annual Accounts cycle to June 2017

The Committee

- **Noted the updated to the Work Plan**

4.4 Matters Arising

There were no matters arising.

ENDOWMENT FUNDS

5. Draft Annual Accounts 2015/16 Tayside NHS Board Endowment Funds (AUDIT50/2016)

The Committee welcomed Mr Crichton, External Auditor for MMG Archbold, who was in attendance for this item.

Mr MacKinnon advised the Committee that the report highlighted the responsibilities of the Audit Committee in terms of the Endowment Fund. It was noted that Mr MacKinnon had reviewed the draft accounts and met with the external auditors following completion of the audit.

Mr Crichton advised the Committee this was the first annual accounts carried out under the Financial Reporting Standard (FRS) 102 and the transition in reporting had gone well providing a clean findings report with no areas for concern and any immaterial errors being reported for information only.

Mr Crichton highlighted the minor errors contained within the report as follows:

- the omission of legacies which had been received post year end. This was due to the timing of the receipt of income
- the omission of a number of accruals from the financial statements. This was due to the timing of the cut off in the current year. It was noted the level had been significantly reduced following the introduction of the PECOS system
- the number of old funds remaining unspent. There was an intention to move funds under £2,000 and those dormant for at least 3 years to unrestricted funds, however, this was in the early stages with no application as yet having been made to The Office of the Scottish Charity Register (OSCR)

It was noted there was a reliance on the work of FTF Internal Audit and there were no concerns over controls.

Mr MacKinnon confirmed a report would be submitted to the Board of Trustees, following the summer recess, taking forward proposals in relation to the unspent and dormant funds.

The Committee

- **Considered the draft annual accounts and recommended that the Board of Trustees should adopt the accounts for the year ended 31 March 2016, and that Professor Connell, in his capacity as Chair of the Board of Trustees, and Ms McLay, in her capacity as Trustee, should sign on behalf of the Board of Trustees:**
    - **The report of the Trustees (page 10)**
    - **The statement of Trustee' Responsibilities for the preparation of the Financial Statements (page 11), and**
    - **The Balance Sheet (page 15)**
- **Considered the Audit Findings Report to the Audit Committee from MMG Archbold**
- **Considered the Letter of Representation to MMG Archbold and recommended that it be signed by Professor Connell, in his capacity as Chair of the Board of Trustees, and Ms McLay, in her capacity as Trustee, on behalf of the Board of Trustees.**
- **Considered the Letter of Confirmation to MMG Archbold and recommended that it be signed by Professor Connell, in his capacity as Chair of the Board of Trustees on behalf of the Board of Trustees**

PATIENTS' FUNDS

6. Patients' Funds – External Audit Report (AUDITR49/2016)

The Committee welcomed Mr Taylor, External Auditor for Henderson Loggie, who was in attendance for this item.

Mr MacKinnon advised that the draft Abstract of Receipts and Payments in respect of Patients' Private Funds was presented for consideration by the Committee prior to submission to Tayside NHS Board.

Mr Taylor advised the Committee that this was the first full year audit following the introduction of the new procedures in June 2014.

Mr Taylor informed the Committee that a small number of errors or system weaknesses were found during the review, however, internal controls in most cases were found to be adequate during audit testing. It was noted that in 2014/15 there were 12 minor action points reducing to 6 minor action points in 2015/16 all categorised as priority C, low risk.

The Committee

- **Reviewed the draft Abstract and Receipts and Payments**
- **Noted the draft audit certificate from Henderson Loggie**
- **Considered the Audit Findings Report from Henderson Loggie**

- **Approved the Recommendation that Tayside NHS Board formally adopts the Abstract of Receipts and Payments in respect of Patients' Private Funds for the year ended 31 March 2016, and authorises the Director of Finance and the Chief Executive to sign the Abstract on behalf of Tayside NHS Board along with the draft letter of representation**

7. EXCHEQUER FUNDS

Mr Hay advised the Committee that Items 7.1 to 7.7 concerned the assurances required for the Audit Committee to approve and recommend the draft report Tayside NHS Board – Assurance by Audit Committee which would be considered under Item 7.8

7.1 Review of System of Internal Control (AUDIT47/2016)

Mr Bedford advised that this report was a scene setter in providing the Committee with the framework for the Committee's review of the system of internal control covered in Item's 7.1 – 7.8 on the Agenda and included the draft Governance Statement (GS) at Appendix 1 of the report.

Mr Bedford highlighted some minor errors contained within this version of the GS as follows:

- Page 1 - minor typo in Tayside Health Board heading
- Page 5 - additional sentence within 3rd paragraph
- Page 9 - Enhancement During Leave – Last sentence to read "An electronic solution will be rolled out across....."

It was noted that these amendments had been reflected within the version of the GS included within Item 7.5 Review of System of Internal Control Lead Officer's Statement to Chief Internal Auditor. It was noted the GS included input from, a range of colleagues and both internal and external audit.

Mr Cross noted that the GS had strengthened from previous years, however, queried what procedures were in place for the Audit Committee to monitor the controls mid-point and highlighted the need for forward planning. It was noted that an Interim Review was submitted to the Committee at its meeting in February 2016. Mr Gaskin advised that Internal Audit would be presenting an Interim Review to the Committee in December 2016 which would be available before February 2017. It was noted Mr Bedford would update the Committee of any issues.

The Committee was asked to review the System of Internal Control and to consider the various terms of its assurance report to Tayside NHS Board. This was to be done by considering each of the reports under Item 7 followed by the conclusion included within Item 7.7 and the Assurance Report at Item 7.8.

The Committee

- **Agreed to review the System of Internal Control and to consider and approve the terms of its assurance report to Tayside NHS Board**

7.2 Annual Reports and Assurances by Committees including Best Value Assurances (AUDIT52/2016)

Mr MacKinnon advised the Committee that all Standing Committees of Tayside NHS Board, with the exception of the Audit Committee, the Board of Trustees and the Governance Review Group had approved their Annual Reports prior to 30 May 2016.

It was noted that Appendix 1 of the report included the overall conclusions from each of these Annual Reports and the Best Value Framework Assurance 2015/16 was included as Appendix 2 of the report. The Best Value Framework Assurance 2015/16 was approved by the Committee at its meeting on 5 May 2016 subject to the inclusion of the Integrated Joint Boards (IJBs) in 2016/17.

Mr MacKinnon advised the Committee that the main function of the Audit Committee was to provide assurance to Tayside NHS Board that an appropriate system of internal control was in place. It was noted Mr Bedford had described work taken place under Item 7.1 of the Agenda.

It was noted that the Audit Committee Annual Report 2015/16 was to be considered separately under Item 7.7 on the Agenda.

Mr Gaskin highlighted that the Clinical and Care Governance Committee conclusion on page 2 of the report did not give assurance on accuracy and effectiveness due to the word "tested" being include within the paragraph *"As a result of the work undertaken during the year I can confirm that measures aligned to the Committee's Terms of Reference tested the effectiveness of clinical governance throughout NHS Tayside services during the year".* Mr Gaskin advised that work carried out by Internal Audit highlighted no concerns and this should be reflected in the conclusion.

The Committee

- **Considered the overall conclusion included within each Standing Committee's Annual Report, Board of Trustees and that of the Governance Review Group and the assurances given therein, in reaching a conclusion on the adequacy and effectiveness of Internal Control in the context of its review of the system of internal control**
- **Noted the Best Value Framework Assurance 2015/16 was approved by the Audit Committee at its meeting on 5 May 2016 subject to the inclusion of the IJBs in 2016/17**

7.3 SHARED SERVICES AUDIT REPORTS (AUDIT53/2016)

7.3a Practitioner & Counter Fraud Services – Service Audit Report

Mr MacKinnon advised the Committee the NHS National Services Scotland (NSS) Service Audit of the Practitioner & Counter Fraud Service had been undertaken in accordance with International Standard on Assurance Engagements 3402 (ISAE 3402), "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board.

It was noted the Service Audit reflected a satisfactory and sound position with fourteen minor control weaknesses identified, a reduction from the sixteen identified the previous year.

The Committee

- **Noted the audit report from the independent Service Auditors**
- **Noted the Introduction by (NSS) Director of Finance and Management Assertion**
- **Noted the management response to the issues arising set out within the action plan**

7.3b National IT Services Contract – Service Audit Report

Mr MacKinnon advised the Committee the NHS National Services Scotland (NSS) Service Audit of the National IT Services Contract had been undertaken in accordance with ISAE 3402, "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board.

It was noted the Service Audit reflected a satisfactory position with eight minor control weaknesses identified. The Service Audit confirmed all minor actions from 2014/15 had been resolved.

The Committee

- **Noted the executive summary of the report of the Service Auditors**
- **Noted the audit report from the independent Service Auditors**
- **Noted the management responses to the issues arising**

7.3c National Single Instance Financial Services Ledger – Service Audit Report

Mr MacKinnon advised the Committee the NHS National Services Scotland (NSS) Service Audit of the National Single Instance Financial Ledger Services (NSI) had been undertaken in accordance with ISAE 3402, "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board. It was noted the report was reviewed and approved by the host Board, NHS Ayrshire and Arran, at its Audit Committee meeting on 13 April 2016.

It was noted the Service Audit reflected a satisfactory position with only minor control weaknesses identified and management responses had been reflected within the report.

The Committee

- **Noted the cover letter from the Director of Finance, NHS Ayrshire and Arran**
- **Noted the Service Audit from the NSI independent Service Auditors, PwC**

7.4 FTF Annual Internal Audit Report 2015/16 (BOARD54/2016)

Mr Gaskin advised the Committee that the report provided an audit opinion based on work undertaken throughout the year and built on audit evidence obtained over a five year audit cycle by Internal Audit and noted that many areas had been covered within the Interim Review.

Mr Gaskin highlighted the amount of added value work which had been undertaken, as part of the annual plan and at the request of management. It was noted this work would be included within the Mid Year Review to be presented to the Committee and Tayside NHS Board in February 2017.

Mr Gaskin advised the Committee that Budgetary Control was graded as D, as was reported in the Interim Review. He stated that this was not necessarily due to a failing of systems, however, there was the need to identify measures for improvement to mitigate increased financial risks. Mr Gaskin noted the impact of the introduction of the Transformation Programme Board and the revised Financial Plan following the Interim Review.

Mr Gaskin acknowledged that achievement of the financial plan in the coming year would be challenging although NHS Tayside was travelling in the right direction.

Mr Gaskin thanked Mrs Jocelyn Lyall and Mr Barry Hudson for work carried out in what had been a challenging year.

Mr Hussain raised concerns regarding the C grade applied to Information Security and queried whether an improvement plan was in place. Mr Hussain also sought assurance regarding the drop in the level of grade A's given from 19 in 2014/15 to 7 in 2015/16.

Mr Gaskin advised that guidance DL 2015/17 had been received highlighting a number of recommendations regarding Information Security with a target date of July 2017. It was noted that these recommendations would be addressed with the support of Ms Margaret Dunning. Ms Dunning advised that the Information Security strategic risk had previously been reported to the Finance and Resources Committee. It was noted that following the retiral of the Information Governance Manager and the cancellation of the December Information Governance Committee meeting work had run off course. Ms Dunning advised that the post of Information Governance Manager had recently been filled and an improvement plan was in place to monitor and address the recommendations set out in DL 2015/17 and was confident there would be an improvement to this grade.

Mr Hay thanked Mr Gaskin and his team for the report and work carried out over the course of the year. The Committee was asked to consider and note the report as part of the portfolio of evidence in support of its evaluation of the internal control environment and the GS, and to take into account the Chief Internal Auditor's conclusion included on page 1 of the report that subject to matters highlighted in the report:

- Tayside NHS Board had adequate and effective internal controls in place
- The 2015/16 Internal Audit Plan had been delivered in line with Public Sector Internal Audit Standards

In addition, take into account that FTF Internal Audit had not advised management of any concerns around the following:

- Consistency of the GS with information that we were aware of from Internal Audit work
- The processes adopted in reviewing the adequacy and effectiveness of the system on internal control and how these were reflected
- The format and content of the GS in relation to the relevant guidance
- The disclosure of all relevant issues. Tayside NHS Board had disclosures in the Treatment Time Guarantee, Enhancements During Leave and Finance

There was agreement from the Committee.

The Committee

- **Noted the FTF Internal Audit Report 2015/16**
- **Considered the report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement**
- **Took into account the Chief Internal Auditor's conclusion included in page 1 of the report**
- **Took into account that FTF Internal Audit had not advised management of any concerns around the 4 areas noted on page 1 of the report**

7.5 Review of System of Internal Control – Lead Officers Statement to Chief Internal Auditor (AUDIT55/2016)

Mr MacKinnon advised the purpose of the report was to advise the Committee of the content of the letter, included within the report, from the Lead Officer to the Chief Internal Officer. Mr MacKinnon advised the Committee the letter from the Lead Officer provided a progress update around internal control during 2015/16, to allow the Chief Internal Auditor to satisfactorily conclude on Internal Audit's work in this area for NHS Tayside in the financial year 2015/16.

It was noted the following appendices were included within the report:

- Appendix 1 – Extract from Public Finance and Accountability (Scotland) Act 2000 – Responsibilities for Accountable Officer
- Appendix 2 – Draft Governance Statement
- Appendix 3 – Responses received from Executive Directors providing further reassurance on Internal Control

The Committee

- **Noted the contents of the letter which was consistent with the Governance Statement guidance, and in particular the assurances contained within the report including those pertaining to the discharge of the responsibilities of the Chief Executive as the Accountable Officer which significantly contributed to the Audit Committee's overall assessment of the system of internal control within NHS Tayside**

7.6 Annual Report – Patient Exemption Checking (PECS) (AUDIT51/2016)

Mr MacKinnon advised the Committee the report detailed the work of the Counter Fraud Services (CFS) during 2015/16 in checking the propriety of exemptions claimed by patients for charges for ophthalmic and dental work. It was noted the report also identified the amounts recovered and those which had been written off.

The Committee was asked to note the 2015/16 Annual Reporting Package from CFS, level of recoveries made by both NHS Tayside and NHS Scotland during 2015/16 and the level of write offs across the Contractor Groups, which were recorded in the losses form (SFR 18) in the 2015/16 Annual Accounts.

It was noted that CFS had recovered on behalf of NHS Tayside £16,602 for 2015/16 (£2014/15 - £16,614). This represented 5.6% (2014/15 – 5.9%) of the Scotland total. The value of write offs had decreased from £12,798 last year to £12,169 this year, which represented 6.3% (2014/15 – 5.2%) of Scotland total.

The Committee

- **Noted the 2015/16 Annual Reporting Package from Counter Fraud Services**
- **Noted the level of recoveries made by NHS Tayside and NHS Scotland during 2015/16**
- **Noted the reported level of write offs across the Contractor Groups**

7.7 Annual Report of NHS Tayside Audit Committee 2015/16 (AUDIT56/2016)

Mr MacKinnon presented the Audit Committee Annual Report 2015/16 to the Committee for consideration and approval prior to its submission to Tayside NHS Board at its meeting on 23 June 2016.

It was noted the Annual Report was in the normal reporting format and described the purpose and composition of the Committee. The Annual Report detailed the membership, frequency of meetings, schedule of business considered and outcomes.

The Committee

- **Approved the Audit Committee Annual Report 2015/16 for submission to Tayside NHS Board**

7.8 Report to Tayside NHS Board – Assurance to the Committee (AUDIT57/2016)

Mr Hay referred to the review of the System of Internal Control included under Items 7.1 – 7.7 of the Agenda and asked the Committee to consider and approve the terms of its assurance report under Item 7.8 of the Agenda. In order to do this, Mr Hay asked the Committee to consider in turn each of the strands of assurance as follows, and Item 3, Declaration of Interests, during the year at other Audit Committee meetings.

1. The introductory paper for the review of the Systems of Internal Control, and Governance Statement (considered under agenda Item 7.1)
2. The Annual reports and assurances for 2015/16, previously submitted by the Standing and other Committees and summarised for the Audit Committee together with Best Value Assurances (considered under agenda Item 7.2)
3. The assurances provided by Scott-Moncrieff as Service Auditor to NHS National Services Scotland on the payment process operated by the Practitioners Services Division,(considered under agenda Item 7.3a)
4. The assurances provided by Scott-Moncrieff as Service Auditor to NHS National Services Scotland on the services provided by the Atos Origin Alliance,(considered under agenda Item 7.3b)
5. The assurances provided by PricewaterhouseCoopers as Service Auditor to Ayrshire & Arran Health Board on the National Single Instance (NSI) Financial Ledger Services,(considered under agenda Item 7.3c)
6. Internal Audit, plans and reports considered by the Audit Committee during the year and the Annual Report (considered under Item 7.4)
7. The Audit Committee's Lead Officer's Statement to the Chief Internal Auditor regarding assurances on internal control and the Governance statement,(considered under agenda Item 7.5)
8. The Annual Report of Patient Exemption Checking, provided by Counter Fraud Service (considered under Agenda Item 7.6)
9. The Audit Committee's 2015/16 Annual Report (approved by the Committee under agenda Item 7.7)

The Committee

- **Considered all evidence and was satisfied assurance could be given to Tayside NHS Board with regard to the systems of internal control operating within NHS Tayside**
- **Approved the Draft Terms of its Assurance Report to Tayside NHS Board and agreed the draft Governance Statement would be signed by the Chief Executive as part of the Accountability Report in the Annual Report and Accounts**

8. Annual Accounts for the Year to 31 March 2016 (BOARD58/2016)

Mr Hay advised that Mr Lindsay Bedford, Interim Director of Finance would present the Annual Accounts for the year ended 31 March 2016 and reminded the Committee that Members were asked not to share the contents of the Annual Report and Accounts with Non Board Members at this stage as it was not permitted to make them publicly available until the audited financial statements were laid before Parliament later in 2016.

Mr Bedford introduced the report by advising the Committee of the following minor updates to the Annual Report and Accounts for the year ended 31 March 2016:

- Page 11 – Tayside NHS Board and Committees – updated to include the text “required by the Scottish Health Plan”
- Page 13 – paragraph added to incorporate Primary Care Practitioners Discipline Committee
- Page 35 – Sickness Absence – updated to reflect NHS Tayside absence rate for 2015/16 as being 5.04% not 5.03%
- Page 41 – Balance Sheets as at 31 March 2016 – Sentence updated to state financial statements were included on pages 39 to 97 not 38 to 96

Mr Bedford advised the Committee that Tayside NHS Board was required under the National Health Service (Scotland) Act 1978 to prepare Annual Accounts and that the Accounts for 2015/16 had been prepared in accordance with the Government Financial Reporting Manual (FReM) issued by HM Treasury which follows International Financial Reporting Standards (IFRS) as adopted by the European Union. The Accounts for 2015/16 include the consolidated accounts of Tayside NHS Board Endowment Funds. The Committee’s role was to consider the Accounts and associated documents and to recommend adoption of the Accounts by Tayside NHS Board.

Mr Bedford provided an overview and highlighted key issues within the draft accounts.

The format of the Accounts was specified in the Financial Reporting Manual (FReM) which incorporates the Scottish Government’s guidance on the accounting policies to be followed in the preparation of the accounts and the additional financial returns.

The Draft Annual Accounts were now presented to the Committee for consideration. The Accounts had been subjected to external audit by PricewaterhouseCoopers. The Endowment accounts had been audited by MMG Archbold and PriceWaterhouseCoopers (PwC) and had taken their assurances from this work.

Boards were now required to prepare an annual report comprising a Performance Report, Accountability Report (which includes the Governance Statement) and the financial statements. This replaced the previous requirement to provide Directors and Strategic Reports. In May 2016 Audit Scotland published a good practice note “Improving the quality of NHS Accounts. The overarching objective of the publication was to help all Boards improve the disclosures included in the Governance Statements to meet the requirements of the Scottish Public Finance Manual. The publication had been reviewed as part of the preparation of the GS included in the Accountability Report.

As part of external audits work, PwC had completed the good practice checklist within the document.

The Draft Annual Accounts pack contained the Performance Report, Accountability Report incorporating the Corporate Governance Report, Directors Report, Governance Statement and Remuneration Report, the Annual Accounts Certificates, Primary Statements, Notes to the Accounts and the Accounts Direction.

A briefing meeting on the Draft Annual Accounts was held on 16 June 2016 with seven Non Executive Directors attending.

The Draft Independent Auditor’s Report (pages 37 & 38) indicated that the auditor would express an unqualified opinion on the Accounts in that the Financial Statements:

- give a true and fair view as at 31 March 2016;
- had been properly prepared in accordance with IFRS;
- and had been prepared in accordance with NHS Scotland Act 1978 and ministerial direction

On Regularity, the draft Independent Auditors’ Report also indicated that the auditor would express an unqualified opinion that, in all material respects, the expenditure and income shown in the financial statements were incurred or applied in accordance with any applicable enactments and guidance issued by the Scottish Ministers.

The draft Independent Auditors Report on other prescribed matters stated that in their opinion:

- The part of the Remuneration Report has been audited in accordance with the NHS Scotland Act 1978 and ministerial direction
- Information in the Performance Report and Accountability Report was consistent with the financial statements

On matters with which the External Auditors were required to report by exception, there is nothing to report.

The Accounts included a Governance Statement (pages 16 to 25) with three disclosures:

- **Waiting Times (TTG) -** The disclosure highlighted the 3,522 patients that exceeded the 12 week Treatment Time Guarantee in 2015/16.

- **Enhancements During Leave (EDL)** - The disclosure highlighted the work that progressed during 2015/16 that indicated the full liability in respect of EDL for the period to 2014/15 as £8.6m in comparison with the initial assessment of £4.4m. The disclosure recognised the additional accrual brought into the accounts for 2015/16 together with the mitigation of the risk going forward through the planned implementation of an electronic solution.

- **Finance** - The disclosure highlighted the financial challenges faced by Tayside NHS Board in the last 4 years and the current unbalanced LDP submission submitted by Tayside NHS Board for 2016/17. It recognised that Tayside NHS Board required further financial brokerage of £5m in 2015/16, giving a total opening balance for 2016/17 of £20m. The disclosure also confirmed the successful, conclusion of both the disposal of the former Ashludie Hospital site, for which Tayside NHS Board required further brokerage in 2014/15 and also Liff Fields. It referenced also the work being taken forward through the Transformation Programme which in conjunction with the National Initiatives are key elements of returning NHS Tayside to a sustainable financially balanced position.

The three issues had been discussed at Tayside NHS Board, Audit and Finance and Resources Committee's during 2015/16.

Also included was a statement of the Chief Executive's responsibilities as Accountable Officer (page 15) and Health Board Members' responsibilities in respect of the Accounts (page 16). In addition the Chief Executive was expected to sign off the Accountability Report (page 36). This was in line with Corporate Governance in the NHS and gives more detailed assurance on the internal systems designed to ensure good financial control within the organisation.

In order for Tayside NHS Board to approve these statements and adopt the Accounts, the Committee was required to submit an Annual Assurance Statement to Tayside NHS Board.

A full set of Draft Accounts was circulated to all Board members.

RESULTS FOR THE YEAR

The Performance Report and the Accountability Report in the Accounts (pages 2 to 25) set out *inter alia* the Principal Activities and Review of the Year, including a summary of the main aspects which impact on the financial position for the year.

A particular highlight was the improved position around Payment Policy on page 14 where average credit in 2015/16 was 10 days a further improvement on 2014/15 and c84% of all invoices paid within the 10 day target.

Tayside NHS Board was set and monitored against three Financial Targets namely the Revenue Resource Limit (RRL), Capital Resource Limit (CRL) and Cash requirement. In 2015/16 all Financial Targets had been met:

- Core RRL - c£764.2m against which there was an underspend of £0.145m;
- Non-Core RRL- c£44.9m – breakeven;
- Core Capital Resource Limit - £11.09m - breakeven
- Cash Requirement - £843.3m - breakeven

The NHS Scotland Efficient Government 3.0% efficiency savings target for NHS Tayside was £20.05m for 2015/16. Efficient Government savings achieved for 2015/16 amounted to £23.4m of which only 35% was delivered on recurring basis.

During 2015/16 Tayside NHS Board committed around £6.8m of the total Capital Resource of £11.1 million to Backlog and Statutory Compliance and Medical Equipment.

The review summarised performance against the key HEAT targets (pages 7 to 8). The position was reported on a regular basis to Members as part of Tayside NHS Board meetings.

The Remuneration and Staff Report section (pages 26-36) drew out the key required elements to be reported on including Executive and Other Senior Employees of Tayside NHS Board as well as the Non Executive Directors. The report contained the requirement around quantification of Pension Benefits. The earnings relationship between the highest earning Director and the median employee was broadly consistent at 6.30 (page 33), with only a small increase on 2014/15. The gender analysis across the NHS Tayside workforce is highlighted on page 35. Referenced earlier in the report is the position on Sickness Absence. Sickness absence increased from 4.83% to 5.04% which continues to sit below the NHS Scotland average but above the 4% target.

The Statement of Comprehensive Net Expenditure, Summary of Resource Outturn in the Accounts and Balance Sheet (pages 39 to 43) provided a summary of key results for the year. The main features were as follows, with the relevant Note to the Accounts indicated.

Staff Costs - Note 2(a) – Page 59
Staff Costs in 2015/16 accounted for £514.7m of the Operating Costs which represented an increase of c3.9% over 2014/15. Consistently staffing accounts for c60% of the Total Operating Costs. Our staff remained critical to our success in improving health and delivering effective healthcare. Effective staff governance and management were critically important to Tayside NHS Board. The increase in cost is due to 1% pay award (all staff), Incremental Movement (AfC), increased agency spend and an increase in number of staff.

Staff Costs Note 2(b) Higher Paid Employees - Page 60
Nursing, AHP, other Scientists, Clinical Psychology and Pharmacy staff were included in the Clinicians section which was a change introduced in 2010/11. The numbers of clinicians remained static at 853.

Hospital and Community Health - Note 4 – Page 61
Gross expenditure at £784.5m an increase of c£22.1m (2.9%) on 2014/15. Local health services accounted for c93% of this spend, other Scottish Board areas c2.0% and Resource Transfer a further c3%. The increase in Private Sector spend at £1.2m (0.15%) was consistent with 2014/15 and recognised both complex care and spend incurred in the independent sector in delivering TTG.

Family Health Services - Note 5 – Page 62
Gross expenditure on Primary Medical, Pharmaceutical, General Dental, and General Ophthalmic Services had increased by c£6m with the bulk of the increase on Pharmaceutical Service c4.6%.

Administration Costs - Note 6 – Page 62
Decrease in costs identified for 2015/16.

Other Non-Clinical Services - Note 7 – Page 62
The definition of this area of expenditure included significant spend on Clinical Compensation Payments, Health Promotion, and Public Health and Endowment Expenditure.

The increase was identified within CNORIS and reflected settlements and provisions made during the year.

Provisions – Note 17 – Page 78
Due to the sensitivity around Clinical/Non-Clinical compensation cases Mr MacKinnon updated the Committee under “reserved business” on the movements within provisions.

Whilst delivering a minor surplus for the year ended 2015/16 Tayside NHS Board recognised the non recurring sources of income that had enabled this position to be derived. Tayside NHS Board commences 2016/17 with £20m outstanding financial brokerage, a culmination of both the current year and previous year brokerage arrangements with the principles governing the profile of brokerage repayments to be set out in the first half of 2016/17. The increasing challenge to maintain quality services and deliver financial sustainability whilst meeting greater demand and expectations, remained a key focus. Tayside NHS Board had, however, set in place a programme that had strong foundations that would seek to build financial resilience and ensure the organisation was fit for the future.

COMMUNICATION OF AUDIT MATTERS

A report on the audit of the 2015/16 Financial Statements from the external auditor was included with the Accounts pack. This report provided an overall review of the audit, highlighted key accounts and audit issues, and incorporated the draft Independent Auditors' Report.

The draft report had been incorporated into the draft Annual Accounts submitted to this meeting and into those going to Tayside NHS Board for adoption at its meeting on 23 June 2016.

Draft Letter of Representation

The Chair and Chief Executive, on behalf of Tayside NHS Board, were required to submit to the auditor a Letter of Representation in connection with the audit.

The draft was attached, and if approved by the Committee would be recommended to Tayside NHS Board at its meeting.

Draft Annual Assurance Statement

The Annual Assurance Statement was the medium through which, after due consideration, the Chair of the Audit Committee would recommend that Tayside NHS Board should adopt the Annual Accounts. A draft Statement was attached.

RECOMMENDATION

The Audit Committee was asked to review

- The draft Performance Report;
- The draft Accountability Report incorporating;
  - The draft Directors report
  - The draft Statement of the Chief Executive's responsibilities as the Accountable Officer of Tayside Health Board;
  - The draft Statement of Tayside Health Board Members' responsibilities in respect of the Accounts;
  - Governance Statement;
  - Remuneration and Staff Report
- The draft Operating Cost Statement;
- The draft Statement of Recognised Gains and Losses;
- The draft Balance Sheet;
- The draft Cash Flow statement;
- The draft Notes to the Accounts;
- The Accounts Direction;
- The draft Letter of Representation

Mr Bedford paid significant thanks to all staff involved in the Annual Accounts process particularly within the Management Accounting and Financial Services functions. Mr Bedford noted in particular the contribution of Mrs Frances Gibson in drawing the Annual Accounts to its present position.

Mr Hay thanked Mr Bedford for the report and advised the Committee that the recommendations would be carried over and revisited at Item 10 following the presentation of Item 9 by the external auditors, PricewaterhouseCoopers.

9. PricewaterhouseCoopers – Annual Report on the 2015/16 Audit to the Board and the Auditor General for Scotland (AUDIT59/2016)

Mr Hay welcomed Mr Kenneth Wilson and Ms Gillian Collin to present the report.

Mr Wilson advised the Committee that the external audit was conducted in accordance with Auditing Standards (International Standards on Auditing (ISAs') (UK and Ireland) and the Code of Audit Practice ('the Code'). The Code explains how external auditors should carry out their functions under the Public Finance and Accountability (Scotland) Act 2000. The audit of financial statements is covered by engagement and ethical standards issued by the UK Auditing Practices Board (APB), so the Code focuses more on the wider functions of public sector auditors. The audit was conducted in accordance with the relevant requirements of the Code.

Mr Wilson advised the Committee that it was the responsibility of Tayside NHS Board and the Chief Executive, as Accountable Officer, to prepare the financial statements in accordance with the National Health Service (Scotland) Act 1978 and directions made there under. It was noted that it was the responsibility of PricewaterhouseCoopers (PwC) in accordance with the Code of Audit Practice to provide Tayside NHS Board with an audit report on the financial statements and the part of the Remuneration and Staff Report to be audited and give an opinion in whether they gave a true and fair view of the financial position of Tayside NHS Board and its expenditure and income for the year, whether they had been prepared properly in accordance with relevant legislation, applicable accounting standards and other reporting requirements, whether the information which comprised the annual report included with the financial statements was consistent with the financial statements and whether expenditure and receipts had been incurred and applied in accordance with guidance from Scottish Ministers.

It was noted that Tayside NHS Board had achieved savings of £23.4m for 2015/16, 3.5 % short of the savings target of £27m. Tayside NHS Board delivered an overall surplus of £0.145m in 2015/16 against its Revenue Resource Limit (RRL) which was achieved by £5m brokerage received from the Scottish Government Health and Social Care Directorate (SGHSCD) in March 2016. Due to a change in funding for the injury benefits provision from core funding to non-core funding. This released £5.6m of core funding which supported the achievement of the overall surplus. It was noted that none of the £15m brokerage received in previous years, which had been scheduled for repayment during 2015/16, had been repaid.

The Committee was advised that the NHS Tayside Local Delivery Plan 2016/17 submitted to SGHSCD in May 2016 had identified a potential deficit of £11.65m for 2016/17. The efficiency target was set at £58.4m of which £5.966m remained unidentified. Mr Wilson advised that although NHS Tayside was facing significant challenges, work was being undertaken through the Transformation Programme Board and a range of National Initiatives to achieve the delivery of these savings. It was noted that should the level of savings required not be achieved there was a significant risk that a larger deficit may occur.

Mr Wilson advised the Committee that NHS Tayside's accounts for 2015/16 had been prepared on a going concern basis, wherein Tayside NHS Board expects to continue operations for the foreseeable future. It was noted that Auditing Standards requires auditors to take into consideration whether preparing accounts on a going concern basis was appropriate.

Mr Wilson informed the Committee that there was a general assumption within the Public Sector that the Scottish Government (SG) would continue to support NHS Boards, however, it was noted that SG had made no formal indication it would provide additional funding, through either increased funding allocation or the provision of additional brokerage to NHS Tayside.

The Committee noted action 1 of the report. "*The Board should consider the implications of not setting a balanced budget for 2016/17 and the ramifications for the Health Board and future service provision if a balanced budget cannot be achieved. The Board should also seek formal clarification from the Scottish Government of the implications of the Board being unable to manage the current gap in the budget resulting in a deficit at year end".*

The Committee noted the Auditor General for Scotland had issued a Section 22 report to the Scottish Parliament's Public Audit Committee to highlight the financial challenges faced by NHS Tayside in relation to the 2014/15 Annual Report and Accounts. It was noted that further brokerage was required in 2015/16, with no brokerage previously received being repaid during 2015/16 and an updated Section 22 report to the Public Audit Committee was anticipated.

Mr Wilson thanked Mr Bedford and Mrs Gibson for their assistance and co-operation during the audit.

Ms Collin spoke to Section 2 of the report, Significant audit and accounting matters. It was noted there had been a further review of the audit plan, following submission of the plan to the Committee in February 2016, which identified an additional area of elevated risk as being valuation of land and buildings. It was considered due to its significance and significant judgement in its valuation to merit being an elevated risk as opposed to a normal risk. This was explained further in the summary of PwC responses to matters identified within the audit plan along with other noted matters arising.

Ms Collin addressed the issue of Enhancements During Leave (EDL) noting that management had identified in 2014/15 that requirements of NHS Circular PCS (AfC) 2008/12, Changes to the way staff are paid during annual leave, had not been fully complied with and were to be remedied. In March 2015 management had recognised an EDL expense of £4.35m, however, following further work undertaken, management identified further payments to be made to staff were required. During 2015/16 management identified a further EDL exposure of £5.006m to bring the total EDL expense to £9.356m, of which £0.8m related to the financial year 2015/16.

It was noted that payments of £5.480m had been paid during 2014/15 and 2015/16, therefore an accrual of £3.516m was required for payments not yet made. Ms Collin advised that although the total expense of £5.006m, which was included within the 2015/16 financial statements, was below the assigned level of performance materiality this was assessed as being a significant risk due to the financial challenges faced by NHS Tayside. The audit procedures evaluated the total EDL expense of £9.356m which had been recognised within the 2014/15 and 2015/16 financial statements. The Committee noted the summary of procedures performed and audit findings of work carried out in relation to EDL detailed within table 1 of the report.

The Committee noted action 2 of the report. *"In financial year 2016/17 management should perform detailed calculations at an individual employee level for EDL arrears arising in 2015/16 and 2016/17. Management should prioritise testing and implementation of the enhanced SSTS functionality across all wards".*

Mr Wilson acknowledged the hard work of management getting systems in place and the historical elements such as record keeping causing difficulties, however, was confident moving forward annual leave would be monitored correctly with the use of SSTS. It was noted NHS Tayside had conducted a more comprehensive review than carried out by other Health Boards.

Ms Collin highlighted table 2 of the report the summary of asset disposals during 2015/16, table 3 which detailed the 24 assets currently classified as assets held for sale noting the table on page 16 of the report showing the key for IFRS 5 classification criteria.

The Committee noted action 3 of the report. *"Whilst there is no significant impact on the financial outturn of the Board, management should regularly undertake a review of the assets held for sale listing in order to ascertain that all conditions of IFRS 5 are met and the assets disclosed as held for sale are appropriate.*

Property receipts do form part of the future income of the Board and therefore it is important that the anticipated value and timing of the sales are closely monitored to ensure they remain realistic".

Ms Collin advised the Committee that there are been 37 cases identified where reversal of unutilised provision had been credited to general ledger accounts disclosed as core, rather than Annual Managed Expenditure (AME) funded. This had no impact on the net operating costs disclosed within the Statement of Comprehensive Net Expenditure (SOCNE), however, the Summary Of core revenue Resource Outturn (SORO) total core expenditure was understated by £0.252m and total non-core expenditure was overstated by £0.252. Tayside NHS Board had corrected this in the final accounts.

The Committee noted action 4 of the report. *"The Board should review its CNORIS accounting practices to ensure that reversal of unutilised provisions is recognised against annually managed expenditure".*

Ms Collin confirmed that based on normal audit procedures, PwC do not disagree with the disclosures contained within the Governance Statement.

Ms Collin referred to Section 3 of the report which detailed financial performance including, brokerage, financial challenges and efficiency savings.

Ms Collin advised of one minor control weakness identified during the audit. It was noted that testing of the payroll systems identified a number of instances where the person authorising the joiner/leaver form was not included in the list of authorised signatories. Following further investigations it was confirmed that in the concerned instances the form had been signed off by someone of suitable seniority but the authorised signatory list had not been updated. It was recommended that authorised signatory lists should be regularly reviewed and updated.

Ms Collin made reference to risk management and performance management contained within Section 4 of the report and advised that the action plan and completed actions were included within appendices 1 and 2 of the report.

Mr Hay thanked Mr Wilson and Ms Collin for a comprehensive report.

The Committee

- **Noted the PricewaterhouseCoopers – Annual Report on the 2015/16 Audit to the Board and the Auditor General for Scotland**

10. Recommendation to the Board of Annual Accounts

Mr Hay advised the Committee that having reviewed the system of internal control, the Annual Report and Accounts and considered the view of the external auditor, the Committee was asked for approval of the recommendations detailed within Item 8, Annual Accounts for the year ended 31 March 2016.

The Committee

- **Approved the recommendation to Tayside NHS Board that the summary of Losses and Special Payments contained in SFR 18.0 and separately included under agenda Item 16 be approved.**
- **Approved the recommendation to Tayside NHS Board, the adoption of the annual accounts.**
- **Approved the recommendation to Tayside NHS Board that authority be granted to sign the documentation specified within Table 1 of the cover report at Item 8, as follows:**
  a. **Performance report (page 9) – Chief Executive**
  b. **Accountability Report (including the Governance Statement) (page 36) – Chief Executive**
  c. **Balance Sheet (page 41) – Chief Executive and Interim Director of Finance**
  d. **Letter of representation to External Auditors – Board Chair and Chief Executive**

11. Notification from Sponsored Body Audit Committees (AUDIT48/2016)

Mr MacKinnon advised the purpose of the report was to inform the Committee of the content of letter received from Scottish Government Health and Social Care Directorate (SGHSCD), attached as Appendix 1 of the report, which intimated the requirement to notify the Health and Wellbeing Audit and Risk Committee of any significant issues of frauds which arose during 2015/16 that were to be considered to be of wider interest.

The Committee was asked to approve the draft response to SGHSCD.

The Committee

- **Approved the terms of the draft response included in Appendix 2 of the report and authorised this to be signed by the Chair of the Audit Committee**

12. Updates to the NHS Tayside Code of Corporate Governance (AUDIT46/2016)

Ms Dunning advised the Committee the purpose of the report was to seek approval of the amendments to the Code of Corporate Governance.

Ms Dunning advised that the amendments and updates were detailed in Appendix 1 of the report. It was noted many of the amendments were minor housekeeping issues along with amendments required as a result of an Internal Audit report.

The Committee

- **Scrutinised the amendments and updates, detailed in Appendix 1, to the Code of Corporate Governance and recommended Tayside NHS Board's approval of these at its meeting on 23 June 2016.**

13. ATTENDANCE RECORD

The Committee

- **Noted the Attendance Record**

14. DATE OF NEXT MEETING

The next meeting of the Audit Committee will take place on Thursday 1 September 2016 at 9:30am in the Board Room, Conference Suite, Kings Cross.

Subject to any amendments recorded in the Minute of the subsequent meeting of the Committee, the foregoing Minute is a correct record of the business proceedings of the meeting of Tayside NHS Board Audit Committee held on 21 June 2016, and approved by the Committee at its meeting held on 1 September 2016.

....

CHAIR **DATE**

STAFF GOVERNANCE COMMITTEE **Item 9.4.2**

Minute of the above meeting held at 2:00pm on **Tuesday 21 June 2016** in the Board Room, Kings Cross, Hospital.

Present
Ms Jenny Alexander, Co-Chair Workforce and Governance Committee, NHS Tayside (to item 8.11)
Professor John Connell, Chairman, Tayside NHS Board
Mr George Doherty, Director of Human Resources & Organisational Development, NHS Tayside
Mrs Judith Golden, Employee Director, Tayside NHS Board (to item 15)
Mr Munwar Hussain, Non Executive Member, Tayside NHS Board
Mr Hugh Robertson, Non Executive Member, Tayside NHS Board
Mrs Alison Rogers, Non Executive Member, Tayside NHS Board
Mrs Sheila Tunstall-James, Non Executive Member, Tayside NHS Board
Ms Lorna Wiggin, Director of Acute Services, NHS Tayside (rep Ms L McLay)
Apologies
Dr Andrew Cowie, Area Clinical Forum Chair, NHS Tayside
Mr Raymond Marshall, Staff Side Representative, NHS Tayside
Ms Lesley McLay, Chief Executive, NHS Tayside
Professor Margaret Smith, Non Executive Member, Tayside NHS Board
In Attendance
Mr Kenneth Armstrong, Director of Operations (for item 8.9)
Mrs Santosh Chima, Diversity and Inclusion Manager (for item 6.1)
Mr Daniel Courtney, HR Business Lead - Access and Facilities Directorates (for item 8.5)
Dr John Davidson, Consultant Physician, Nuclear Medicine (for item 7.1)
Ms Margaret Dunning, Board Secretary, NHS Tayside
Miss Donna Howey, Head of Committee Administration
Ms Jenni Jones, Associate Director - Development, NHS Tayside
Dr Paul Lewthwaite, Consultant, OHSAS (for items 8.2 & 8.3)
Mrs Pat Millar, Head of Knowledge and Skills, NHS Tayside (for item 1)
Ms Alix Mitchell, Specialist Advisor/Team Leader, OHSAS (for item 8.3)
Mrs Jennifer Mudie, Associate Director of HR – Resourcing, NHS Tayside
Mr Robert MacKinnon, Associate Director of Finance - Financial Services & Governance/Fraud Liaison Officer
Ms D McCulloch, Head of Service, Health & Community Care, Dundee Health & Community Care Partnership (for item 8.2)
Mr Iain McEachan, HR Business Lead (for item 8.2)
Ms Jennifer McIntyre, Modern Apprentice (for item 1)
Ms Eileen McKenna, Associate Nurse Director, NHS Tayside
Mr Ian McLaren, Head of HR - Resourcing (Planning and Information)
Mr Bill Nicoll, Director of Primary and Community Services, NHS Tayside
Miss Diane Robertson, Locality Pharmacist, Area Clinical Forum Representative
Mr Christopher Smith, Head of Human Resources, NHS Tayside

Mr Munwar Hussain in the Chair

ACTION

1. Chairman's Welcome and Introduction

Mr Hussain welcomed all present and paid a particular welcome to Jennifer McIntyre, a modern apprentice healthcare assistant. Jennifer had attended the Young Scotland Programme during 2015 and was to present her experience to the Staff Governance Committee.

Mr Hussain also welcomed Mr Hugh Robertson, Non Executive Board member to his first meeting as a member of the Staff Governance Committee.

It was agreed that the Young Scotland presentation would be taken as the first item on the agenda.

Presentation

Young Scotland Programme – Healthcare Apprentices

Mrs P Millar and Ms J McIntyre were in attendance for this item.

Ms McIntyre gave a presentation on her experience as an attendee of the Young Scotland programme in September 2015. It was noted that the Young Scotland programme existed to develop the communication skills and broaden the horizons of people in the early stages of their working lives.

Ms McIntyre outlined the profile and role of a Modern Apprentice, and why she had applied to the Young Scotland Programme as she was keen to challenge herself and develop her skills.

She outlined what the students had undertaken on the Young Scotland Programme and what had been the key benefits. These included attending an international conference, the wide networking opportunities, gaining confidence and all in a safe environment.

Ms McIntyre advised that all of the NHS Tayside modern apprentices who had attended the Young Scotland Programme had gained employment or were to start college courses. Both the modern apprenticeship and attendance at the programme were credited with giving the participants the confidence and motivation to pursue these careers. Ms McIntyre highlighted the support given by the Tayside NHS Board Endowment Fund to be able to do this.

The Staff Governance Committee congratulated Ms McIntyre and her colleagues on their achievements.

The Director of Human Resources noted that it was important that the Board was recognised as a major employer in the area and acknowledged its social responsibility. He asked Ms McIntyre for her view if anything else could be done to improve the modern apprenticeships. Ms McIntyre advised that more training in different areas whilst on placement would be beneficial.

The Chairman noted that the Education and Training Funding Committee had given the go ahead for the funding of another 4 places on the Young Scotland Programme for 2016.

The Staff Governance Committee:

- **Thanked Ms McIntyre for attending the Staff Governance Committee and for her presentation**

2. Apologies

The apologies were as noted above.

3. Minute of Previous Meeting

3.1 Minute of Meeting held on 16 February 2016

The Staff Governance Committee Minute of the meeting held on 16 February 2016 was approved subject to the undernoted amendment:

It was confirmed that Mrs Frances Gibson was deputising for Mr Robert MacKinnon who usually attended the meeting on behalf of Mr L Bedford.

- **The Minute of the Staff Governance Committee of 16 February 2016 was approved on the motion of Mrs S Tunstall-James and seconded by Mrs J Golden**

3.2 Committee Chair's Assurance Report – Staff Governance Committee Minute – 16 February 2016

The Committee Chair's Assurance Report – Staff Governance Committee Minute (16 February 2016) was noted and had been submitted to the Board**.**

3.3 Action Points Update

The Director of Human Resources advised that actions were either completed, on this agenda or there was a timescale to come forward to a future meeting of the Staff Governance Committee.

- **The Staff Governance Committee noted the Action Points Update**

4. Matters Arising

There were no matters arising.

5. Declaration of Interests

There were no declarations of interest.

6 Staff Governance Standard

6.1 Treated Fairly and Consistently (SGC/2016/15)

Mrs S Chima was in attendance and spoke to this report. She highlighted a couple of points:

Page 3, under Equal Pay Audit, the findings of the refreshed Equal Pay Audit had been reported to the Staff Governance Committee in April 2015. This work helped to determine if NHS Tayside was meeting the objective to provide equal pay.

A new requirement was now in place under the amended Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012. It required all listed public authorities to publish the gender composition of their Boards and produce succession plans to increase the diversity of their boards and the threshold for listed authorities had been lowered on their gender pay gap and equal pay

statements, from those authorities with more than 150 employees to those with more than 20 employees.

A report had been presented to the Staff Governance Committee in October 2015 on the measures of certificate to recruit, training and workforce diversity data on protected characteristics and this report provided an update on that position and reports would come forward on a regular basis to give assurance.

During discussion the following points were noted:

- The benchmarking of diversity data was queried. It was noted that the main benchmark was against the local population and the SWISS system held information about protected characteristics
- There was an Equality and Diversity National Lead Network that assisted in shared learning
- There was still times when recruiting panels had no members who had undertaken certificate to recruit training. It was noted that progress with this has been slower than expected. This had been raised recently at the Senior Management Team meeting. It was the intention for this to be a mandatory requirement for managers at all levels in the organisation. An Internal Audit report about this was due to come to the Staff Governance Committee in December 2016 **J Jones/J Mudie**
- Concern had been expressed by the Staff side at the recording and monitoring of disciplinary and grievance cases. It was noted that dismissals related to health were not included in the figures. It had been agreed that future reporting would be done in partnership with the Staff side
- There was a legal requirement to have data on bullying and harassment cases in relation to the protected characteristics. It was important that this data was input correctly
- In the main, job adverts were looking to recruit internally rather than externally. It was suggested this could have an adverse effect on the diversity of the organisation. It was noted that this reflected ongoing work to re-profile the non front facing staff workforce

The Staff Governance Committee:

- **Noted the progress made against the Staff Governance Standard "Treated Fairly and Consistently"**
- **Agreed that an update on Certificate to Recruit would come to the December 2016 meeting** **J Jones/J Mudie**
- **Noted that future reporting would be done in partnership with staff side, before coming to the Staff Governance Committee.**

6.2 People Matter Strategic Framework (SGC/2016/16)

The Director of Human Resources & Organisational Development advised that a full refresh of the Framework had been undertaken. He noted that there was a mandatory requirement to deliver "Everyone Matters" on behalf of the Scottish Government Health and Social Care Directorate, and this framework helped deliver that commitment.

The Framework had been fully consulted upon and the Director of Human

Resources & Organisational Development commended its adoption by the Staff Governance Committee.

During discussion the following points were noted:

- In response to a query about how progress would be tracked, it was noted that each item would have an action plan and outcomes from iMatter would also assist with this
- There was a proposal to establish a sub-group of the Staff Governance Committee – the People Committee. This would be co-chaired by the Director of Human Resources & Organisational Development and the Employee Director. This sub-group could provide twice yearly or quarterly updates on progress with actions to the Staff Governance Committee
- It was suggested and agreed that the People Matter Strategic Framework should go to the Board for information

The Staff Governance Committee:

- **Noted the outcome of consultation on the 'People Matter' Strategic Framework**
- **Agreed the adoption of the Framework document and that it should be submitted to the Board for information**

Director of HR & Organisational Development

6.3 Developing Our Culture (SGC/2016/17)

The Director of Human Resources & Organisational Devlopment spoke to this paper. He outlined the previous discussion at the Board meeting on 26 May 2016, where it had been agreed that the Staff Governance Committee should discuss this and agree the next steps.

Ms Jones advised that if the Staff Governance Committee were in agreement, the diagnostic phase would take place over a six month period with the intention to refresh and develop NHS Tayside's culture.

During discussion the following points were highlighted:

- There had been a significant amount of work done around culture in the organisation three years ago – "The Big Conversation". It was felt that there should be enough information already to assist with a cultural diagnostic. Concern had also been expressed in the comments given in the People Matter survey that there was not a lot of confidence in the culture of the organisation
- This was a tested tool for culture, it had Kings Fund Support and the initial sign up was for a discovery phase of identifying the current culture within the Board. There was no cost attached to this
- It was likely that the report on the discovery phase would be available in December 2016
- This approach gave support to employees rather than telling them what to do
- It was important that staff did not feel let down by another process that gathered information but then appeared to stall

The Staff Governance Committee:

- **Considered the report and agreed use of the Kings Fund toolkit on behalf of the Board**
- **Receive and decide follow up action upon receipt of report at its December 2016 meeting**

Director of HR & Organisational Development

7. Governance Risks

7.1 Strategic Risks

Medical Workforce (SGC/2016/18)

Mrs J Mude and Dr J Davidson were in attendance for this item.

Ms Mudie highlighted the impact of junior medical staffing on the medical workforce as a whole.

Dr Davidson gave a detailed report on the actions taken to mitigate this risk in respect of medical workforce recruitment. He highlighted that this was subject to market forces but this year, there had been good recruitment to training posts in NHS Tayside. There had been an oversubscription of foundation doctors. At year 1 and 2 level, core specialities were almost full but there were vacancies in core surgery and primary care/GP training posts. It was noted that this was a national problem.

Other specialities struggling to recruit were higher medicine, psychiatry and higher surgery. This had a knock on effect to service provision with gaps in rotas as well as the training status if rotas were non compliant.

It was highlighted that with social media and other information sources, doctors were readily aware of these types of quality issues and would react accordingly in choosing their place of work.

During discussion the following points were noted:

- An update on medical education was to be given to the Board on 23 June 2016 by the Post Graduate Dean
- Discussion was ongoing about holding welcome events with senior medical students and welcome packs. It was suggested that an upgrade of the student accommodation at Ninewells would be welcomed.
- The importance of the availability of employment for spouses was highlighted. It was noted that the availability of employment for non medical spouses was being taken forward with the local authorities. The availability of employment for medical spouses was a recruitment issue. Those with family and childcare commitments would be more interested in more flexible working arrangements

The Staff Governance Committee:

- **Noted the content of Report SGC/2016/18**

7.2 Workforce Optimisation (SGC/2016/19)

Mrs J Mudie spoke to this report. She advised that the strategic risk in relation to Workforce Optimisation was currently identified as amber.

It was noted that the Whole Time Equivalent (WTE) figure that should have been included in the Datix extract under current performance was 11758.5.

During discussion, it was felt that the risk rating of this rate was low in comparison to the other two workforce risks.

The Staff Governance Committee:

- **Noted the content of Report SGC/2016/19**

7.3 Nursing and Midwifery Workforce (SGC/2016/20)

Ms McKenna was in attendance and spoke to this report. She highlighted the key risks and gave a progress update on e-rostering.

The Staff Governance Committee:

- **Noted the content of Report SGC/2016/20**

It was noted that the new risk assurance report template had been introduced that outlined the relevant information needed for the Board and Standing Committees to receive assurance on the strategic risks of the organisation delegated to them. This had been approved by the Board in March 2016 and future reporting of these workforce strategic risks, to the Staff Governance Committee would be through this new style of assurance reporting.

8. Monitoring Reports

8.1 Workforce Information Report – Quarter 4 and Annual Report 2015/16 (SGC/2016/21)

Mrs J Mudie spoke to this report.

During discussion, Mrs Alexander highlighted that there was a lot of activity in relation to grievances and disciplinary matters that appeared to have been recorded. She expressed the view that this report should be routinely submitted to the Area Partnership Forum before coming forward to the Staff Governance Committee.

It was noted that there needed to be consistency in this reporting and that there was a timing issue around the submission date for information.

The Staff Governance Committee:

- **Noted the content of the report**

8.2 Promoting Attendance at Work – Quarter 4 2015/16 Report (SGC/2016/22)

Mr C Smith presented this paper. He advised that there had been an increase in the sickness absence rate in some areas. It was noted that NHS Tayside was still one of the better performing NHS Boards in relation to sickness absence.

At the last meeting of the Staff Governance Committee, concern had been expressed about the levels of sickness absence in the Mental Health, the Dundee CHP and the Operations Directorates. Mr Smith advised that Mr Armstrong and Ms McCulloch were in attendance for any questions in relation to the action plans submitted by the Operations Directorate and Dundee CHP Directorate respectively.

The Chairman highlighted that the rate of sickness absence in the Operations Directorate had improved significantly. Mr Armstrong advised that the rate had reduced from 6.91% to 5.19% and while this was going in the right direction, it still required to be monitored by the Staff Governance Committee.

Ms D McCulloch advised that the Dundee CHP Directorate had been doing well at the beginning of 2015/16, but that the rate had increased from October 2015 onwards. It was noted that this was during the transition over to the new health and social care partnerships.

Mr I McEachan advised that this had been due to a combination of factors and there was a connection to the organisational change but it was not solely due to that. It was noted that long term sickness absence had significantly reduced between the third and fourth quarters of 2015/16.

Mrs J Golden noted that the action plans in place for the Operations and Dundee CHP Directorates were robust and were assisting in improving the sickness absence rates. She highlighted the number of cases of stress, anxiety and depression that were included in the reasons for absence in Table 4 and queried if there was anything else that could be learned and applied in these cases.

Mr Smith advised there were a number of factors that influenced these cases and a number of these were external to the working environment. A strategic approach to managing this type of absence including improving well being and supporting staff when issues arose. It was highlighted that that there were difficulties in accessing the Wellbeing Centre on Staffnet and this would be investigated and resolved.

Dr Lewthwaite advised that stress/anxiety was a common reason for sickness absence across NHS organisations. He highlighted that one approach taken was to risk assess stress at the higher level in the organisation.

It was highlighted that the second highest reason for absence was “unknown cause”. It was noted that cause of illness unknown and unexplained could be entered at the start of a sickness absence, and as full as information would be recorded during, or at the end of the absence period. It was noted that there was significant empirical evidence that this type of absence was reduced in relation to the culture of an organisation.

The Staff Governance Committee:

- **Noted the content of the report and that a further update will be brought to a future meeting of the Staff Governance Committee**

8.3 Reducing "Did Not Attend (DNA)" Appointments Report and Actions (RC/2016/23)

Ms A Mitchell and Dr P Lewthwaite were in attendance for this item. Ms Mitchell outlined the work that had been undertaken in trying to reduce the number of DNA appointments at OHSAS.

She advised that the Occupational Health Team was limited in terms of what could be done about the non attendance of employees to their service. It was noted that text messaging had been considered, however, this had IT implications. It was also costly in terms of staff resource to phone employees in advance of their appointment.

During discussion the following points were highlighted:

- There were a number of factors why an employee did not attend for an occupational health problem. These included line managers not releasing staff, employees moved to other posts or left NHS Tayside or they were too unwell to attend appointments. It was noted that if a member of staff was no longer employed , their OHSAS referral should be cancelled as a matter of course
- DNA activity impacted significantly on clinical activity. This level of DNA would be unacceptable in clinical services. There was a need to learn from the improvement processes that had been put in place in the clinical service to reduce DNA rates. It was suggested that Mr C Smith and Dr P Lewthwaite should discuss this further with Ms Wiggin and Mr Nicoll to see what could be done and bring an update back to a future meeting of the Staff Governance Committee

The Staff Governance Committee:

- **Noted report RC/2016/23**
- **Receive a future report on improvement** — **C Smith/ P Lewthwaite**

8.4 Staff Governance Committee Report : Annual Report Recruitment Activity 2015/16 (SGC/2016/24)

Mrs J Mudie presented this report. She highlighted that in 2015/16 there had been less external recruitment. It had in the main been internal recruitment and the ambition was to develop staff within the organisation.

It was noted that hard to fill vacancies were included as part of the Workforce Plan to be considered later in the agenda.

The Staff Governance Committee:

- **Noted report SGC/2016/24**

8.5 Staff Governance Monitoring Framework (SGC/2016/25) :

Local Monitoring Template and Assessment Tool Return 2015/16
National Annual Monitoring Return 2015/16
Staff Governance Standard Action Plan 2015/17

Mr D Courtney was in attendance and spoke to this report.

Mrs Golden advised that it had been agreed at the Area Partnership Forum that the local monitoring returns should not be submitted to this meeting of the Staff Governance Committee as they had not been agreed in partnership and therefore did not form part of the national return. This was to have been included with the narrative to the return to the Scottish Government.

It was noted that there was ongoing work to strengthen partnership working in NHS Tayside and that this was an iterative process.

It was noted that submission of the return had been delayed until 22 June 2016 and the relevant amendments would be made before it was submitted.

The Staff Governance Committee:

- **Noted the 6 monthly update to the Staff Governance Action Plan 2015-2017**
- **Approved the National Annual Monitoring Return to be signed off by the Chair of the Staff Governance Committee, Chief Executive and Employee Director (including narrative about the non submission of the Local Monitoring Template for submission to the Scottish Government)**
- **Noted the further partnership work that had to be done in completing the Local Monitoring Template and Assessment Tools**

8.6 Area Partnership Forum Board Summary Report 26 January 2016 (SGC/2016/26)

The Staff Governance Committee:

- **Noted the Area Partnership Forum Board Summary Report 26 January 2016 for information**

8.7 Area Partnership Forum Board Summary Report 23 March 2016 (SGC/2016/27)

The Staff Governance Committee:

- **Noted the Area Partnership Forum Board Summary Report 23 March 2016 for information**

8.8 Nursing and Midwifery Workforce Planning Activity across NHS Tayside 2015-16 : Summary Progress Report (SGC/2016/28)

Mrs E McKenna spoke to this item.

The Staff Governance Committee noted:

- **The ongoing application and embedding of the workload tools within NHS Tayside in accordance with CEL 32 (2011)**

- **The progress made in applying the national Nursing and Midwifery**

Workload/Workforce planning tools and methodologies to clinical environments across NHS Tayside during 2013-2016 and the scheduling process that will support the application of robust nursing and midwifery workforce planning systems and processes for the future.

- **The importance of collegiate working to ensure that as an organisation NHS Tayside has the right staff with the right skills, in the right place at the right time to meet patients' needs**

- **That NMWWP was not just about a numerical outcome; the outcome was multi-factorial in nature and an ever evolving process that takes into consideration the variables in terms of the wider aspects of nursing and midwifery workforce planning and has patients, patient safety and delivery of effective as the core of decision-making**

- **The significant contribution that NHS Tayside has made to the national programme and the ongoing development of the national workload tools**

8.9 Safe and Improved Working Environment – Update

Mr K Armstrong advised that due to changes with the support provided by OHSAS, work was ongoing to recruit a Health and Safety Manager and a Compliance Manager to add rigour to the system.

The Director of Human Resources & Organisational Development assured the Committee that a dedicated resource had been allocated to support health and safety in the organisation. It was noted that interim cover was in place until both posts were appointed to.

The Director of Human Resources advised that one of the Staff Governance Standards was the safety of staff and an update on this was to be provided at the next meeting of the Staff Governance Committee.

The Staff Governance Committee noted the verbal update

8.10 Update on Improvement Notices

Ms L Wiggin gave an update on the improvement notices that had been given to NHS Tayside following a visit by the Health and Safety Executive (HSE) on 24 and 25 November 2015.

She gave the background to the three improvement notices that had been given to Dundee Dental Hospital and to the three that had been given to Ninewells. It was noted that improvement work had been done and the HSE was content with compliance for all notices within the timeframe.

Ms Wiggin paid a particular thanks to Mrs Audrey Warden, General Manager Specialist Services Directorate and Mr Iain Dorricott, HSE Support Officer for their work in this respect. There had also been a significant amount of work undertaken by Ms Kerry Wilson, General Manager, PRI and Dr Alan Cook,

Medical Director, Operational Unit in respect of medical staff training.

Ms Wiggin highlighted that the improvement notice in respect of skin health surveillance had been served on OHSAS and NHS Fife as the OHSAS employer. It was noted that there was to be discussion later in the agenda in respect of the provision of occupational health services in Tayside.

The Chairman noted the assurance provided by Ms Wiggin and highlighted the important role of the Compliance Officer. He asked that the staff involved in this work be recognised in the all staff, Staff Governance communication update.

The Staff Governance Committee thanked Ms Wiggin for her verbal report and noted the update

Mrs Alexander left the meeting.

8.11 Non Executive Whistleblowing Champion 2015/16 Report (SGC/2016/31)

Mrs A Rogers advised that the Whistleblowing Policy had been updated. She advised that she was meeting colleagues from other NHS Board areas on 22 June to discuss the use of whistleblowing processes.

The Staff Governance Committee:

- **Noted the content of the report and that future updates will be provided to the Committee at 6 month intervals**

8.12 Update on NHS Tayside Scheme for Medical Appraisal and Revalidation (SGC/2016/32)

Professor Hussain was unable to attend and this item would be carried forward to the September Staff Governance Committee meeting.

Committee Support Officer

The Staff Governance Committee:

- **Agreed that this item should be carried forward to the next meeting in September**

10. Annual Reports/Work Plans/Plans

10.1 Tayside NHS Board Annual Report of Remuneration Committee 2015/16 (SGC/2016/33)

The Staff Governance Committee:

- **Noted the Annual Report of Remuneration Committee 2015/16**

10.2 Annual Report of Area Partnership Forum 2015/16 (SGC/2016/34)

The Staff Governance Committee:

- **Noted the Annual Report of Area Partnership Forum 2015/16**

10.3 Tayside NHS Board Annual Report of Staff Governance Committee 2015/16

(SGC/2016/35)

The Staff Governance Committee:

- **Noted the Annual Report of Staff Governance Committee 2015/16**

10.4 Terms of Reference Staff Governance Committee 2016/17 (SGC/2016/36)

The Director of Human Resources & Organisational Development advised that a formal report would come forward to the next meeting of the Staff Governance Committee with the updated Terms of Reference for the Staff Governance Committee

Director of HR & Organisational Development

The Staff Governance Committee:

- **Noted that a formal report was to come to the September meeting of the Staff Governance Committee seeking approval of the revised Terms of Reference**

Director of HR & Organisational Development

11. Items for Adoption

11.1 Healthy Working Lives Organisational Guidelines (SGC/2016/37)

The Staff Governance Committee:

- **Approved the Healthy Working Lives Organisational Guidelines**

11.2 HR Policies (SGC/2016/38)

- **Employee Conduct**
- **Facilities and Time Off for Trade Union Duties**
- **Breastfeeding and Returning to Work**
- **Paternity, Parental and Shared Parental Leave Policy**
- **Whistleblowing Policy**
- **Bank Policy**
- **Smoking Policy**

It was noted that all polices had been recommended for endorsement by the Area Partnership Forum, except the Smoking Policy. The Area Partnership Forum considered this a management policy.

The Staff Governance Committee:

- **Endorsed the Polices as listed above**

12. Items for Information

12.1 Area Partnership Forum Minute – 26 January 2016

The Staff Governance Committee:

- **Noted the Area Partnership Forum Minute of 26 January 2016**

12.2 Area Partnership Forum Minute – 23 March 2016

The Staff Governance Committee:

- **Noted the Area Partnership Forum Minute of 23 March 2016**

12.3 Workforce and Governance Forum Minute – 2 March 2016

The Staff Governance Committee:

- **Noted the Workforce and Governance Forum Minute of 2 March 2016**

12.4 Supporting NHS Tayside Staff Who Care for Someone Outside Work

The Staff Governance Committee:

- **Noted the information pack that was available for NHS staff who were carers**

12.5 "Valuing People" – Personal Development Plans (PDPs) Development of a Whole System/Personal Development Plan (PDP) Improvement Plan for 2016/17 Update(SGC/2016/41)

The Staff Governance Committee:

- **Noted the content of report SGC/2016/41 and the ongoing progress with implementation of the action plan**

12.6 Record of Attendance

The Record of Attendance was noted for information.

13. Any Other Competent Business

There was no other competent business.

For Governance Reasons, it was proposed that the following items be taken in reserved business.

In Accordance with the Freedom of Information (Scotland) Act 2002 Exemption 27(1)

14. Corporate Workforce Plan 2016 Workforce Projections (SGC/2016/39)

The Staff Governance Committee :

- **Endorsed the content of the Corporate Workforce Plan and Workforce Projections on behalf of the Board noting the points made by the Employee Director and the work commissioned in respect of partnership working**

15. Occupational Health Strategic Direction (SGC/2016/40)

The Staff Governance Committee :

- **Noted the decision of the Chief Executive to support creation of in-house Occupational Health and Health & Safety teams**
- **Agreed to receive future reports on Occupational Health and Health & Safety service design and performance**
- **Noted that a further report would come to the September meeting of the Staff Governance Committee**

16. Date and time of the next meeting

The next meeting of the Staff Governance Committee will take place on Tuesday 27 September 2016 at 2pm in the Board Room, Kings Cross.

Subject to any amendments recorded in the Minute of the subsequent meeting of the committee, the foregoing Minute is a correct record of the business proceedings of the meeting of the Staff Governance Committee held on Tuesday 21 June 2016 and was approved by the Committee at its meeting held on Tuesday 27 September 2016.

…… ……..

Chair Date

Minute NHS Tayside

Tayside NHS Board

CLINICAL AND CARE GOVERNANCE COMMITTEE – OPEN BUSINESS

Minute of the above meeting held at 13:30 on **Thursday 11 August 2016** in the Board Room, King's Cross, Dundee.

Present

Professor John Connell	Chair, Tayside NHS Board
Dr Andrew Cowie	Non-Executive Member, Tayside NHS Board
Mrs Linda Dunion	Non-Executive Member, Tayside NHS Board
Cllr Glennis Middleton	Non-Executive Member, Tayside NHS Board
Mrs Alison Rogers	Non-Executive Member, Tayside NHS Board **(Chair)**
Professor Andrew Russell	Medical Director, Tayside NHS Board
Professor Margaret Smith	Non-Executive Member, Tayside NHS Board

Apologies

Mrs Gillian Costello	Nurse Director, Tayside NHS Board
Mrs Judith Golden	Non-Executive Member, Tayside NHS Board
Mr Stephen Hay	Non-Executive Member, Tayside NHS Board
Ms Lesley McLay	Chief Executive, NHS Tayside

In Attendance

Mr Alan Cook	Medical Director - Operational Unit and Consultant, NHS Tayside
Ms Margaret Dunning	Board Secretary, Tayside NHS Board
Mrs Alison Hodge	Committee Support Officer, NHS Tayside

Mrs Alison Rogers in the Chair

ACTION

1 APOLOGIES

The apologies were noted as above.

2 WELCOME AND INTRODUCTION

Mrs Rogers welcomed everyone to the meeting. Ms Donna Kelbie was attending with Ms Tracey Passway on behalf of Ms Arlene Napier.

3 MINUTE OF PREVIOUS MEETING

3.1 Minute of the Clinical and Care Governance Committee Open Business held on 12 May 2016

There were no comments in relation to this minute. The minute of the Open Business of the Clinical and Care Governance Committee held on Thursday 12 May 2016 was approved as an accurate record on the motion of Ms Linda Dunion and Professor Andrew Russell.

The Committee:

- Approved the minute of the Open Business of the Clinical and Care Governance Committee held on Thursday 12 May 2016

DRAFT

3.2 Action Points Update Clinical and Care Governance Committee 11 August 2016 Open Business

The Medical Director provided a verbal update on the following:

4. Clinical Services Strategy

The Medical Director advised the Shaping Surgical Services Strategy would go to the Tayside NHS Board in October 2016.

6. Draft Clinical and Care Governance Committee Terms of Reference 2016-17

In relation to the development of a governance diagram the Medical Director advised that some issues were being progressed.

The remainder of the action points were contained within reports on the agenda.

The Committee:

- Noted the verbal update

3.4 Matters Arising

There were no matters arising.

4 Declaration of Interests

There were no declarations of interests.

5 Governance

Clinical and Care Governance Committee Workplan 2016-17 Open and Reserved Business

The Committee:

- Noted the Clinical and Care Governance Committee Workplan 2016-17 Open and Reserved Business

7 Assurance

7.1 Strategic Risks Aligned to the Clinical and Care Governance Committee (CCGC/2016/26)

Ms Hilary Walker was in attendance to facilitate the risk discussion. There was a short discussion and explanation of the three levels of risk: strategic, organisational and service level.

Ms Walker advised that the report provided a position statement for activity during 2015/16. There were currently seven strategic clinical risks that reported to the Clinical and Care Governance Committee.

From the report Ms Walker highlighted that the Maternity Services risk had achieved the planned risk exposure and consideration should be given to archiving this risk or consider as a service level risk for Maternity Services.

DRAFT

The Committee noted that the Managed/ 2C General Practice Provision Risk had been circulated in draft for comments to the risk owner/manager and would be aligned to the Clinical and Care Governance Committee. The owner of this risk is the Medical Director and the manager is the Associate Medical Director, Primary Care.

There was a discussion on the assurance report (approved by the Tayside NHS Board) for use when providing assurance to Standing Committees. It was agreed that the assurance report template would be used for all future reporting of strategic clinical risks to the Committee.

Ms Dunning commented that Strategic Risk Reports were an important source of assurance and would enable the Committee to be aware of the steps that were being taken to mitigate risk within NHS Tayside.

Following discussion the Committee requested that the covering table be provided to show the position on a rolling basis month to month in order to enable a trend analysis. H Walker

It was agreed, going forward, that Datix reports would not be required but could be included as a separate appendix for information.

15 Delivering Care for Older People

Owner – Gillian Costello	Yellow Risk
No change to the owner	No change to the scoring of this risk

This risk was last updated on 12 July 2016 and continued to be updated by the risk manager after each meeting of the NHS Tayside Older Peoples Clinical Board. The risk review date would be 25 October 2016.

16 Clinical Governance

Owner – Andrew Russell	Amber Risk
No change to the owner	Change to the scoring of this risk

The risk was downgraded in April 2016 and was reported at the CCGC. The risk is continually reviewed by the Head of Clinical Governance and Risk.

22 Health Protection of Children and Young People

Owner – Gillian Costello	Yellow Risk
No change to the owner	No change to the scoring of this risk.

The Committee noted that there would be a review of this risk wc 15 August 2016. The current risk owner is retiring and consideration will be given to a new risk manager. Noted also that the Angus Inspection may impact on the risk score.

23 Mental Health Services

Owner – Karen Ozden	Risk now an Operational Risk
No change to the owner	(Mental Health Services Quality Improvement)

Ms Walker advised that this risk had been updated and downgraded in status to an operational risk to focus on improvement work. It has been replaced by new strategic risk reference 395. There will be further discussion at the Strategic Risk Management Group on 15 August 2016 in respect of the owner and manager.

DRAFT

121 Person Centredness

Owner – Gillian Costello
No change to the owner

Yellow Risk
No change to the scoring of this risk

There were no issues to be highlighted to the Committee.

144 Maternity Services

Owner – Gillian Costello
No change to the owner

Amber Risk
No change to the scoring of this risk

Previously discussed.

302 PRI Patient Flow

Owner – Alan Cook
No change to the owner

Amber Risk
A change to the scoring of this risk

Dr Cook advised that the risk had been downgraded on 3 August 2016. The next review would be on 3 November 2016.

The Committee provided feedback on the current method used for providing assurance to the CCGC. It was agreed that an early warning on risks would be beneficial to highlight emerging issues.

The Medical Director highlighted the importance of the CQF risk discussions to provide assurance to the Committee.

The Committee:

- Noted the update
- Noted that the risk assurance template would be used for future strategic risk reporting with the option of Datix print outs

7.2 Annual Report of the NHS Tayside Donation Committee 2015-2016 (CCGC/2016/27)

Dr Stephen Cole was in attendance for this report. The Committee noted that the NHS Tayside Donation Committee was jointly Chaired by Dr Cole and Professor Connell.

Dr Cole advised that the Donation Committee met four times per year and was made up of a mixture of lay and professional persons. The remit of the Committee was to ensure that all opportunities for donation within NHS Tayside were met.

The Donation Committee focussed on:

- Encouraging public engagement
- Liaison with the media to raise awareness to maximise donation opportunities in Angus, Dundee and Perth and Kinross

Dr Cole advised that there had been a significant increase in people signing donation forms. Donation could only be considered if the patient dies within in an intensive care environment.

The Committee noted that last year there were 22 organs available and 19 individuals

DRAFT

had received life saving surgery in NHS Tayside.

Dr Cole explained that organ transplant was life changing for an individual but could be viewed as a cost effective option and discussed the example of a patient receiving dialysis and treatment versus receiving a kidney transplant.

There was a short discussion on the opt in option scheme in Scotland and the soft opt out option scheme in Wales.

Dr Cole advised that Scottish Government and the Scottish Donation Transplant Group were developing legislation for a soft opt out option system.

Dr Cole highlighted the some of the challenges faced:

- There is a national shortage of Intensive Care (ICU) beds and this was an impediment
- Nationally and locally one quarter of the patients say no to organ transplant
- Funding will always required to generate publicity

The Medical Director commended the outcomes of the Donation Committee that NHS Tayside adopted an impressive holistic approach to organ donation.

The Committee:

- Noted the NHS Tayside Donation Committee Annual Report 2015-2016
- Commended the outcomes of the Committee and its approach to maximising donation opportunities within NHS Tayside

7.3 NHS Tayside's Annual Feedback Report 2015/16 (CCGC/2016/35)

The Annual report for 2015-16 detailed the issues raised and the learning, actions and improvements made, or proposed, in response to the feedback received between 1 April 2015 and 31 March 2016. Ms Sarah Lowry was in attendance for this report.

The Annual report was positively received by the Committee and the links to access more information was highlighted as being beneficial.

Ms Lowry advised that in 2015/16 there was strong focus on encouraging feedback and that the development of validated tools for the collection of patient feedback was progressing well. The team were now exploring how to spread this success to other areas.

The Committee were encouraged by the creativity and the different approaches that were being made to obtain feedback.

It was noted, however, that there was still a reliance on IT to obtain feedback. A question was asked about how feedback was collated from people with learning disabilities and travelling community. Ms Lowry acknowledged that there were still hard to reach groups and that the feedback team were working closely with Partnership Forums and the third sector to improve this.

The report described areas where there were challenges:

- The timescales associated with complaints
- The spread of learning to other areas of the organisation

There were concerns raised in relation to the fall in complaints response time to 46%.

There was a further discussion on response letters and whether they were unnecessarily complex and if they could be simplified.

In was highlighted that in relation to Health and Social Care Partnership complaints and NHS sign off it was important that there was no further delay to reply letters.

The Committee noted that the Annual report is required to be submitted to the Scottish Government and the Health Improvement Scotland by 30 June 2016. Feedback on the NHS Tayside submission would be expected in October 2016.

The Committee were advised that there would be a review of complaints handling and a national review of the process during 2016-2017. Noted that the Nurse Director, the Chief Operating Officer and an external consultant would be supporting this review.

The Committee were advised that feedback and complaints were discussed regularly at Senior Leadership Team meetings and at Performance Review meetings.

Information in relation to actions that have taken place and spread of learning from complaints is now being discussed Performance Review meetings.

The Committee:

- Noted the report
- Acknowledged that there had been an improvement in the quality of the Annual Feedback Report year on year
- Noted the different approaches and the role of the volunteers
- Agreed that going forward it was important to ensure that there was engagement with providers of care (HSCI)
- Noted the work of the Performance Review to close the loop

7.4 Safer Management of Controlled Drugs (CDs) 2015/16 (CCGC/2016/36)

Ms Lucy Burrow and Ms Frances Rooney were in attendance for this report which was submitted annually to the Committee by the Controlled Drugs Accountable Officer.

From the report the Committee noted the responsibilities of the Controlled Drugs Accountable Officer:

- Ensuring safe and effective management of controlled drugs
- Routine monitoring of the use of controlled drugs
- Inspection of relevant premises
- Ensuring suitable arrangements for the disposal of controlled drugs
- Gathering and sharing of intelligence
- Investigation concerns
- Providing support and advice

Ms Rooney highlighted that the Local Intelligence Network was well developed in Tayside and that there was a strong national collaborative.

The Committee had no questions in relation to this report.

The Committee:

- Noted the report which provided assurance regarding local implementation of the strengthened governance arrangements for the safer management of controlled drugs

DRAFT

7.5 Clinical Governance and Risk Management Update (1.2.16 – 31.3.16) (CCGC/2016/28)

7.6 Clinical Governance and Risk Management Update (1.4.16 – 31.5.16) (CCGC/2016/29)

Ms Tracey Passway and Ms Donna Kelbie were in attendance for the report. The Committee had no questions in relation to the two reports. Mrs Rogers acknowledged that the report had evolved and was now easier for the Committee to read and interpret.

The Committee:

- Noted the reports and the activity by the Clinical Governance and Risk Management Team

7.7 Scottish Patient Safety Programme in Primary Care Report (CCGC/2016/30)

Ms Diane Campbell was in attendance for this report. The report provided the Committee with an update on patient safety activity undertaken by General Practices (GPS) as part of the Scottish Patient Programme during year three and the areas for focus for the next year.

The Committee noted that thirty GP practices had signed up to use the Results Handling Programme as a substitute for the Trigger Tool SQ007(S) and Climate Survey QS008 (S).

The Quality and Outcomes Framework was dismantled in April 2016 and the Quality and Safety Indicators QS007 and QS008 are no longer part of the General Medical Services Contract.

The Committee noted that there had been a Sharing and Learning event for results Handling event in June 2016. GP Practices are being encouraged to focus on the deteriorating patient and awareness sessions in respect of the introduction of the National Early Warning System (NEWS) had taken place ahead of the its introduction on 1 August 2016.

Ms Campbell advised that there was a newsletter to keep GP practices updated on the Patient Safety work.

In addition to this a new Area Drugs and Therapeutic Committee for Medicines Safety and Quality has been set up to take forward Medicines Safety.

The Committee:

- Noted the report and progress
- Acknowledged the work to improve safety in Primary Care including results handling, deteriorating patient and medicines harm

7.8 Scottish Patient Safety Programme Acute Adult Report (CCGC/2016/37)

Ms Diane Campbell was in attendance for this report. As previously agreed at the Tayside NHS Board a selection of Patient Safety reports would be provided to the Committee over a period of twelve months.

Ms Campbell highlighted that this report had been considered by the CQF on 18 July 2016 and the following actions were agreed:

- To minimise the data burden work would be required to ensure, where possible

the Performance Reviews provide assurance on the ten essentials of safety and the core elements of the Scottish Patient Safety Programme
- To avoid unnecessary duplication, reports that are used locally to provide assurance would also be used to provide Health Care Improvement Scotland with NHS Tayside's progress against the aims of the Acute Adult programme

From the detail in the report the Committee noted that at the end of 2015 the Acute Adult programme undertook a 90 day process to consider the content and delivery method of the next stage of the SPSP. The recommendations were as follows:

- 2016-2017 would be transitional year to build on the progress with existing workstreams
- The focus of national reporting would be on outcomes where possible
- The focus on process measures as a key component of the improvement work locally will remain
- National support for testing of process measures will concentrate on the development of guidance on potential process measures and, where required, advice on which ones to test

The Medical Director highlighted the importance of the work around the avoidance of duplication and the reduction of data. This was as a good example of seeing the links to the CQF, Performance Reviews and providing assurance.

The Committee:

- Noted that requirements and challenges of reporting the Scottish Patient Safety Programme – Acute Adult programme and the progress and plans to date

7.9 Out of Hours Service Update (CCGC/2016/44)

Ms Jillian Galloway, Ms Sue Mackie and Dr Michelle Watts were in attendance for this report. The report provided the Committee with an updated position in respect of the Out of Hours service.

The Out of Hours service was currently managed through the hub at Kings Cross Health and Community Care Centre. Care is being delivered in patient's homes and in each of the Primary Care Emergency Centres (PCEC) in Kings Cross, PRI and Arbroath Infirmary.

The Out of Hours Service was consolidated at the Out of Hours Hub at the Kings Cross Health and Community Care Centre in September 2015. During this period there has been consideration given to what was required to ensure the safe delivery of the service.

The team has worked with GP's in Perth and Kinross and short surgeries have been running from Spring 2016. There has also been a nurse led service in Perth Primary Care Emergency centre (PCEC).

Ms Galloway advised that canvassing with GPs was successful and First5® salaried and sessional GPs were now in place.

NHS Tayside has successfully bid for:

- Additional shift/ roving GP in Perth and Kinross to support patients in their home who were unable to travel to Dundee
- Establish a nurse led telephone triage service within the Out of Hours Service
- Introduced band 2 Health Care Assistants to release Band 5 nursing time to continue to redirect patients safely

- To run a test of change in partnership with the Emergency Medicine Department to support co-working between the two departments by having a Senior Primary Care Nurse in Emergency Medicine at peak times at the weekend to support Emergency Medicine with patients presenting with primary care issues

Dr Watts advised that there had generally been an improvement and this has been well supported and positively received. Newer doctors (First5® GP's) are being recruited due to the refreshed Out Of Hours environment.

Dr Watts added that although changes have been made we are moving into the winter period and there is not yet a level of confidence that a sustainable situation has been reached.

It was agreed that the Committee should receive a further report in February 2017 to include an update on the National Implementation Plan.

The Committee highlighted the importance of the general public being aware of the services that are available via regular updates from the Communications department.

Dr Cowie requested information in respect of the red incident on the last page of Appendix 1. Ms Galloway advised that she would respond directly to Dr Cowie with this information.

The Medical Director acknowledged the enormity of professional and personal commitment to ensure the Out of Hours Service operated.

Dr Watts highlighted:

- The requirement for robust recruitment and retention for GPs, Occupational therapists, pharmacy and nursing staff to ensure sustainable models of care
- Development of relationships with the Scottish Ambulance Service in respect of primary responders
- The need to improve the interface with IT systems

The Committee:

- Noted and supported the work undertaken to date by the service to support the safe delivery of the Out of Hours Service going forward
- Noted the current position and arrangements within the out of hours service to ensure adequate safe levels of cover within the out of hours service and maintain patient safety
- Support the ongoing/ future work and further pilots to further improve the service and to develop a more integrated service between in and out of hours and a multidisciplinary approach to delivering the service
- Acknowledged the enormity of professional and personal commitment that has been made to ensure the Out of Hours Service operated
- Noted that a sustainable situation would be required for the winter period
- Noted that a further report to the Committee in February 2016 would include information on the national plan — J Galloway, M Watts
- Agreed the importance of the population knowing when to contact the Out of Hours service

8 Local and National Reports

8.1 Mental Welfare Commission Report of the announced visit to Rohallion Secure

DRAFT

Care Clinic (CCGC/2016/41)

The announced visit to the Rohallion Clinic took place on 10 March 2016. The Medical Director highlighted that the report detailed positive comments about the service and that there were no recommendations.

The Commission highlighted the following areas of good practice:

- Care, treatment, support and participation
- Participation
- Care planning
- Rights and restrictions including specified persons arrangements
- Activity and occupation
- The physical environment
- Engagement with carers

Mrs Rogers acknowledged that this was a very positive report and congratulated Dr Ozden and her team.

The Medical Director extended an invite to Board members to visit to Rohallion Secure Care Clinic.

The Committee:

- Noted the content of the report and the very positive comments as described in the Mental Welfare Commission Report
- Noted the value of the financial investment and time commitment made by the service to the Royal College of Psychiatrists Quality Network for Forensic Care

9 Policies and Guidance

9.1 Duty of Candour Update (CCGC/2016/38)

Ms Walker was in attendance for this report. The report provided an update on progress in relation to the development of the Duty of Candour guidelines. The remit of the Scottish Government Duty of Candour sub group was attached for information. She advised that November 2016 report to the Committee would include the formal report on the workshop.

Ms Walker confirmed that the Duty of Candour would not be a specific policy but would be contained within the current Adverse Event Policy. Noted that the Adverse Event Policy was currently being reviewed.

Ms Walker advised that there was a test module in the Datix system to look at information that would be included in respect of the Duty of Candour requirements.

Mrs Rogers requested an update at each meeting. H Walker

The Committee:

- Noted report and the progress to date in relation to the development of the Duty of Candour guidelines

9.2 Extravasation Policy (CCGC/2016/31)

9.3 Covert Medication Policy (CCGC/2016/32)

DRAFT

9.4 Prescribing of Non Formulatory Medicines (including Individual Patient Treatment Requests) (CCGC/2016/33)

9.5 Review of the Policy for Records and record Keeping for Nursing and Midwifery Staff (CCGC/2016/34)

The Medical Director confirmed that each of the policies had received a significant level of scrutiny at the Clinical Quality Forum (CQF) and the Area Drug and Therapeutics Committee (ADTC).

There was a short discussion on the practicalities of the implementation of the Prescribing of Non Formulatory Medicines Policy. This would be progressed outwith the meeting.

The Committee:
Adopted the following Policies:

- Extravasation Policy
- Covert Medication Policy
- Prescribing of Non Formulatory Medicines (including Individual Patient Treatment Requests)
- Review of the Policy for Records and record Keeping for Nursing and Midwifery Staff

10 Items for information and action as required

10.1 Record of Attendance

The Committee:
Noted the record of attendance

11 Items for internal and external Communication

The Committee highlighted the Out of Hours Service for further communication.

12 AOCB

No items.

For Governance Reasons, it is proposed that the following items be taken in Reserved Business

In accordance with the Freedom of Information (Scotland) Act 2002 Section 30

13 Minute of the previous meeting

13.1 Minute of the Clinical and Care Governance Committee Reserved Business 12 May 2016

The Committee:

- The minute of the Reserved Business of the Clinical and Care Governance Committee held on Thursday 12 May 2016 was approved as an accurate record on the motion of Ms Linda Dunion and Professor Andrew Russell.

13.2 Action Points Update Clinical and Care Governance Committee 11 August 2016

DRAFT

The Committee:

- Noted the Action Points Update

14 Items for Discussion

14.1 Chair's Assurance Report for the Clinical Quality Forum (CQF) meeting held on 23 May 2016 (CCGC/2016/45)

The Committee:

- Noted Chairs Assurance Report for the Clinical Quality Forum (CQF) Action Note 23 May 2016

14.2 Perth Royal Infirmary – Strategic Risk ID302 – Key Measures (CCGC/2016/42)

The Committee:

- Noted the performance against key measures
- Noted how the risk stratification score had been used to review and reduce the risk exposure rating
- Requested an update at each meeting

14.3 Murray Royal Hospital Adult Mental Health Inpatient Care: Update on Health and Safety Executive Investigation and Improvement Notice (CCGC/2016/39)

The Committee:

- Noted the updated position in respect of the progress that had been made
- Noted the content of the detailed action plan
- Noted that the risks associated with the Improvement Notice were being actively mitigated, managed and controlled
- Noted that the risks associated with the Improvement Notice had an appropriate level of governance, assurance and reporting through the Committee
- Noted the updated position in respect of the progress that has been made and recognised that there would be delays due to procurement procedures due to costs being above an identified level
- Noted that plans were in place to progress procurement via the Finance and Resources Committee
- Required assurances from both NHS Tayside and Perth & Kinross Health and Social Care Partnership (HSCP) that continuity of managerial responsibility and professional leadership of Mental Health will be maintained, that oversight of the HSE action plan will continue and that clarity as regards accountability within the new hosting arrangement will be reached as soon as possible
- The Committee requested a report from the Accountable Officer at its next meeting in November 2016

14.4 Care Inspectorate: Services for Children and Young People in Tayside

The Committee:

- Noted that there would be a report at the next meeting

In accordance with the Freedom of Information (Scotland) Act 2002 Section 36(2), Section 38

15 Items for Discussion

DRAFT

15.1 Scottish Public Services Ombudsman Reports (CCGC/2016/43)

The Committee:

- Noted the report and the learning outcomes for NHS Tayside
- Requested additional information regarding the current status regarding learning outcomes relating to the complaints
- Requested that future reports to the Committee contain information on any Procurator Fiscal reviews, recommendations from health following FAI outcomes

15.2 Public Health Directorate Performance Review Framework Period 1 April – 31 July 2016 (CCGC/2016/40)

The Committee:

- Noted the report

15.3 NHS Education for Scotland (NES) triggered visit to Stracathro Hospital

The Committee:

- Noted the verbal update and that the formal report of the visit was awaited

16 Items for information and action as required

No items

17 AOCB

The Medical Director led a short discussion on Performance Review meetings.

18 DATE OF NEXT MEETING

The next meeting of the Clinical and Care Governance Committee will take place on Thursday 10 November 2016 at 1:30pm within the Board Room, Kings Cross.

Subject to any amendments recorded in the Minute of the subsequent meeting of the committee, the foregoing Minute is a correct record of the business proceedings of the meeting of Tayside NHS Board Clinical and Care Governance Committee held on 11 August 2016 and was approved by the Clinical and Care Governance Committee at its meeting held on 10 November 2016.

CHAIR **DATE**

DRAFT

Minute NHS Tayside

TAYSIDE NHS BOARD
FINANCE AND RESOURCES COMMITTEE - OPEN BUSINESS

Minute of the meeting of Tayside NHS Board Finance and Resources Committee held at 09:30 a.m. on **Thursday 18 August 2016** in the Committee Room 1, Level 10, Ninewells Hospital, Dundee

Present:
Dr A Cowie, Non Executive Member & Chair of Area Clinical Forum, NHS Tayside
Mr D Cross, OBE, Non Executive Member, Tayside NHS Board
Councillor D Doogan, Non Executive Member, Tayside NHS Board
Mrs L Dunion, Non Executive Member, Tayside NHS Board
Mrs J Golden, Non Executive Member, Tayside NHS Board
Cllr K Lynn, Non Executive Member, Tayside NHS Board
Attending – Executive Directors
Mr L Bedford, Director of Finance, NHS Tayside
Mr G Doherty, Director of Human Resources, NHS Tayside
Mr R MacKinnon, Associate Director of Finance - Financial Services & Governance/FLO, NHS Tayside
Professor A Russell, Medical Director, NHS Tayside
Regular and Other Attendees
Mr M Anderson, Head of Property, NHS Tayside
Mrs G Culross, Senior Communications Manager, NHS Tayside
Mrs A Dailly, Information Governance Officer, NHS Tayside (for items 7.3, 10.1 & 10.2)
Mr N Deuchar, Senior Property Manager, NHS Tayside
Ms M Dunning, Board Secretary, NHS Tayside
Mr A Gall, Financial Consultant
Mrs L Green, Committee Support Officer, NHS Tayside
Dr M Ibrahim, Deputy Director of Medical Education (Undergraduates) (for item 8.1)
Mrs L Lyall, Capital Finance Manager, NHS Tayside
Mr S Lyall, Head of Finance, Operational Unit, NHS Tayside
Mr R Marshall, Representative Area Partnership Forum
Mr D Mills, Representative Area Clinical Forum, NHS Tayside
Apologies
Prof J Connell, Chair, Tayside NHS Board
Ms L McLay, Chief Executive, NHS Tayside
Miss D Robertson, Representative Area Clinical Forum

Mr D Cross in the Chair

ACTION

1. CHAIRMAN'S WELCOME AND INTRODUCTION

Mr Cross welcomed all to the first Committee meeting following the summer break.

Mr Cross welcomed Dr Mohammed Ibrahim, Deputy Director of Medical Education (Undergraduates), in attendance for Item 8.1 on the Agenda, Professor Andrew Russell, Medical Director attending on behalf of Ms Lesley McLay, Chief Executive and Mr Alan Gall, Financial Consultant.

It was noted Mr Gall was working with Ms McLay and Mr Bedford in relation to benchmarking exercises and was also an attendee at the Transformation Programme Board.

2. APOLOGIES

The apologies were noted as above.

3. DECLARATION OF INTERESTS

There were no declarations of interests.

4. MINUTE OF PREVIOUS MEETING

4.1 Minute of the Finance and Resources Committee Minute – 12 May 2016

The Finance and Resources Committee Minute of the meeting held on 12 May 2016 was approved on the motion of Mrs Linda Dunion and seconded by Mrs Judith Golden.

4.2 Action Points Update

Mr Bedford spoke to the Action Points Update.

Reporting Requirement – Code of Corporate Governance – It was noted that discussions were ongoing with Mr Michael Cambridge, Associate Director of Procurement, regarding the identification of suppliers where negotiation of longer term contracts may be possible.

Assurance Report on Strategic Financial Plan – It was noted an update regarding the progress of the Transformation Programme had been incorporated into the Assurance Report on Financial Risk and the Corporate Financial Report, both of which were Agenda items for this meeting.

It was noted all other actions had been completed.

It was agreed that Item 8.1 Additional Cost of Teaching Annual Update Report 2015/16 would be taken next on the Agenda

8. ANNUAL REPORTS/WORK PLANS/PLANS

8.1 Additional Cost of Teaching Annual Update Report 2015/16 (FRC44/2016)

Mr Bedford advised that the Committee received the Additional Cost of Teaching (ACT) Annual Update report for noting. It was noted the NES Performance Management Framework required NHS Tayside to account for the use of ACT funding. An abbreviated report was submitted to NES for performance management purposes.

Mr Bedford introduced Dr Mohammed Ibrahim, Deputy Director of Medical Education (Undergraduates) to speak to the report.

Dr Ibrahim advised the Committee that ACT had received funding in excess of £12m from NES in 2015/16. This contributed to a range of different aspects of teaching with clinical teaching receiving the highest allocation. It was noted approximately 90 – 95% of teaching was led by NHS Tayside staff.

Dr Ibrahim advised that quality assurance and improvement was monitored by NES by way of red, amber and green flags. It was noted NHS Tayside had not received any red flags from NES. NHS Tayside had the only Medical School in Scotland where no red flags had been received for 2015/16.

Dr Ibrahim advised the Committee there was a reduction of £300k in funding for 2016/17, however, there was confidence this would be managed. Some resources had been used to cover joint activities between undergraduate and post graduate activities as discussed with ACT previously. The aim to have a process by which this could be justified by working closely in NHS Tayside to deliver high quality under and post graduate teaching taking into account patient safety and experience. It was noted NES was looking to justify funds allocated to NHS Tayside. Dr Ibrahim was confident that all funding received from NES would be justified.

Dr Cowie raised concerns around the substantial amount of money NHS Tayside spent in outsourcing students to other Health Boards. Dr Ibrahim advised that students were outsourced due to the lack of capacity within NHS Tayside. It was noted agreement was required from Clinical Leads and Directors for increasing capacity and suggestions and involvement in discussions would be welcomed.

9:40 Cllr Ken Lynn arrived

Professor Russell noted that NHS Tayside being one of the highest performers in Scotland was encouraging. The importance of building on education was recognised. It was noted NHS Tayside had robust processes in place to adapt to changes within teaching.
Dr Ibrahim wished to thank and acknowledge the work of the ACT team.

Mr Cross acknowledged the good work of Dr Ibrahim and his team and the recognition from NES that NHS Tayside was performing at a high level.

The Committee

- **Noted the content of the report and that of the Annual Update Report 2015/16**

4.3 Work Plan 2016/17

Mr Cross advised the Committee that the Work Plan 2016/17 was to be a regular Agenda item and had been updated to include Forward Planning 2017/18. This would be reported to the Committee at its meetings in November 2016 and January 2017.

5. Matters Arising

There were no matters arising

6. GOVERNANCE ISSUES

6.1 Capital Report for the Period Ended 30 June 2016 (FRC46/2016)

Mrs Lyall advised the Committee the report detailed the capital position of NHS Tayside for the period ended 30 June 2016.

Mrs Lyall referred to Table 1 of the report which compared the current capital forecast for 2016/17 with the Capital Plan which had been approved by Tayside NHS Board in May 2016. The approved Capital Plan had subsequently been included in the Local Delivery Plan (LDP) which was submitted to Scottish Government Health and Social Care Directorate (SGHSCD) in May 2016.

Mrs Lyall noted the shift of £37k between the approved and forecast Capital Plan and advised the confirmed capital funding for 2016/17 from Capital Resource Limit (CRL) was £11,383m, which included £0.717m capital grants. The June SGHSCD allocation letter had confirmed CRL of £14.175m with significant allocations and adjustments anticipated.

It was noted Table 2 of the report highlighted a reconciliation of the CRL at 30 June 2016 with the June allocation letter.

Mrs Lyall advised the anticipated outturn for 2016/17 was a breakeven position and the Capital Scrutiny Group (CSG) would continue to monitor progress to ensure this target was met. The Non Added Value (NAV) revenue element of funding to support the Capital Plan was estimated at £2m for the year and would continue to be monitored throughout this financial year. Annually Managed Expenditure (AME) impairment on projects within the project plan was currently estimated at £1.211m on current year completions.

It was noted the May LDP forecasted the disposal of 16 properties with a Net Book Value (NBV) of £2.941m, with a further NBV of £0.014m identified in respect of equipment disposals from the fixed asset register. The total NBV of £2.955m would be returned to SGHSCD, however, discussions were ongoing with SGHSCD regarding the use of asset receipts, inclusive of NBV, to assist NHS Tayside's revenue position being retained by NHS Tayside.

The Committee noted that the current contract period for estate revaluation services would end 30 September 2016 and an invitation to tender was issued on 16 June 2016 with a closing date of 5 July 2016. It was noted this was an item on the Agenda for this meeting and details of the tender exercise would be reported under this item.

Mrs Lyall highlighted the gross capital expenditure to 30 June 2016 was reported at £1.667m, comprising CRL of £1.437m and NAV revenue of £0.229m. This was comparable with the gross expenditure of £0.931m for 2015/16. The graph on page 3 of the report detailed the profile of capital spend compared to 2015/16 and the 2016/17 expenditure profile as per the LDP Capital Plan allowing for comparison with the actual expenditure. It was noted the 2016/17 forecast expenditure was currently in line with the 2016/17 LDP forecast spend profile and with

progression of projects resulting in changes to the capital forecast, comparisons between the 2016/17 forecast and LDP forecast would become more apparent.

The gross forecast capital expenditure of £18.018m was detailed within a chart on page 3 of the report with the highest proportion of forecast gross expenditure expected on EAMS (including infrastructure projects) at 21.5% and ring fenced Radiotherapy Equipment Replacement at 21.5%. It was noted EAMS funding had been allocated to tackle infrastructure, statutory compliance and backlog maintenance issues.

The overall budget increase at 30 June 2016 was £0.077m and the net budget changes across the main expenditure headings were detailed in Table 3 with a detailed breakdown of the budget changes by project included in Appendix 3 of the report.

It was noted slippage of £1.226m was returned to SGHSCD in 2015/16, of which £1.100m was returned to NHS Tayside in the June allocation letter, and a further £0.126m was anticipated.

The report identified a number of continuing issues which had had an impact on the Capital Plan for 2016/17 and would continue to impact in future years. In particular, there were significant pressures on the NAV budget in 2016/17, being mainly due to the high level of proposed spend on revenue equipment from the IM&T allocation. As the eHealth Investment Programme was not considered capital it would require to be written off against the NAV budget. It was noted that approximately 65% of the IM&T rolling programme allocation is expected to be revenue, however, there was no identified source of revenue funding for essential IM&T equipment and there was an urgent need to identify an annual revenue funding earmarked for IM&T within future NHS Tayside Financial Plans.

Mrs Lyall advised the Committee that the current national contract of telephony services is due to end in November 2017 and as a result NHS Tayside was required to replace telephony facilities throughout Tayside. It was noted tenders had initially been sent out under the assumption that the replacement would be carried out as a full managed service contract, to include equipment, and therefore be a revenue solution, however, tender returns have indicated that companies would not include equipment as part of the managed service and as a result equipment would be required to be funded through capital. It was noted that confirmation of capital costs was awaited but was estimated to be circa £1.3m to £1.4m, a requirement every five to seven years, and would include set up costs of circa £225k. This had not been included within the Five Year Capital Plan.

The Committee noted the East Central Territory hub (ECT hub) was monitoring progress on a number of projects and the status of each of these was detailed within the report. The ECT hub shareholders forum had been rescheduled from 7 June 2016 to 27 September 2016 and the 2015 hub KPI would be presented at this forum with results being submitted to the November 2016 Committee meeting.

Mr Bedford advised the Committee that NHS Tayside were submitting bids in respect of a £100m allocation from SGHSCD to support health and a level of allocation was expected.

Mrs Lyall advised, in response to a query from Mr Cross, that telephony equipment, such as handsets, would not be included within a fully managed services contract as alternative companies providing services following the end of a contract would not want to take ownership of the original equipment. It was noted that this was previously a revenue lease but would now be a capital lease. Mr Cross requested that options were explored with an update to a future Committee meeting. **LL**

Mr Gall highlighted the importance of the disposal of fixed assets and queried whether there were improvements in NHS Tayside's capacity to take forward disposals. Mr Anderson advised the team had been bolstered by the addition of five members of staff and although one position remained outstanding there had been a significant improvement.

Mr Cross advised a significant point had been raised within the report, in areas of significant expenditure, there was the need for better planning, the need to ensure resources were sufficient and areas were being addressed through maintenance.

The Committee

- **Requested options in relation to telephony equipment and fully managed service contracts were explored with an update at a future Committee meeting**
- **Noted the Capital Report for the Period Ended 30 June 2016**

6.2 Corporate Financial Report for the Period Ended 30 June (FRC47/2016)

Mr Cross advised the Committee that a different style of reporting had been adopted for this item to allow Members to gain a clear understanding of the financial challenges faced by NHS Tayside and to ensure transparency.

Mr Bedford advised the Committee that this reporting structure was at an early formative stage and feedback would be appreciated. It was noted reporting of the Integrated Joint Boards (IJB) position would also evolve over the coming months and would recognise the change of status for this delegated resource approved by Tayside NHS Board in March 2016 as part of the Financial Framework.

Mr Bedford highlighted the key points of the report. The position as at Quarter 1 was an overspend of £4.480m against the May 2016 position of £2.884m. This was an increase on the deficit of £1.596m within the month and recognised the unbalanced Local Delivery Plan (LDP) position submitted to Scottish Government (SG) in May 2016 and a deterioration of c£1m anticipated for each month.

The position was summarised in the Core Operational function detailed within Table 1 of the report and subjectively in Table 2.

The Financial Framework which was approved by Tayside NHS Board in March 2016 sought to resolve a number of legacy issues and was reflected in the base budgets which operational and strategic functions received at the beginning of the year, however, the efficiency savings in both the present year and in the medium term were recognised.

The Board Contingency remained intact in the reporting of the position at Quarter 1. The 3 elements of the £4.480m overspend position were £2.9 unbalanced LDP, £1.2m shortfall on efficiencies and c£0.4m net cost pressures.

It was noted Table 2 of the reported highlighted an overspend position of £1.4m in relation to pay. This position was detailed by job family in Table 3 of the report and the monthly spend profile and trend in Whole Time Equivalent (WTE) worked was shown in Chart 1 of the report. It was noted WTE since March 2016 had fallen

10:10 Mrs Alison Dailly arrived

The monthly trend profile was detailed in Table 4 of the report with some months reflecting Public Holidays and 5 week months in relation to weekly paid staff.

Mr Bedford advised that supplementary costs were detailed in Table 5 of the report and in graphical format in Appendix 2 of the report. It was noted there had been a reduction of £531k in supplementary costs in 2016/17 from the same period in 2015/16. The WTE workforce had fallen by 173 WTE since March 2016. The main contributors to this were Nursing and Midwifery and Admin and Clerical/Senior Managers.

Pressures remained within a number of non compliant rotas for Training Grade Medical staff and contributed £0.3m to the financial position. It was noted these costs would remain until the training grade changeover in August 2016. Cost pressures would lessen with continued compliance.

The Committee noted that eRostering continued to be rolled out across the organisation. This together with the Safecare System would significantly enhance Tayside NHS Board's ability to provide timely, robust information to ensure the efficient deployment of the workforce resource. There was the expectation this would allow for a reduction in supplementary costs and would be reported to the Transformation Programme Board (TPB).

The winter surge beds on the Ninewells site remained open with no identified funding source reflecting continued patient flow. There was a cost pressure of £0.34m identified to date.

Mr Bedford advised prescribing was highlighted within Table 6 and Chart 2 of the report. Secondary Care prescribing continued to support the position overall taking into account the challenge with FHS prescribing costs resulting in a shortfall of c£0.2m in 2015/16. It was noted each of the IJBs had indicated through their own governance processes the challenges of remaining within the identified financial limits. The Prescribing Management Group would continue to work collaboratively.

The Committee noted non pay costs were detailed within Table 7 and Chart 3 of the report. The Workstream Programme was active in ensuring products were procured at the most economical price. It was noted benefits from the national pricing scheme were apparent within energy, in particular, for gas. Mr Bedford advised that clinical supplies continued to be impacted by demand pressures.

Individual Group positions were highlighted within Section 3.7 of the report with the intention to provide a better understanding on each aspect of the organisation in terms of trends, particular areas of traction in containing costs and areas where pressures were evident. It was anticipated this would be enhanced in future months to recognise forecast outturn positions.

It was noted the Committee may wish to invite representatives from specific areas within the organisation to gain a greater insight and understanding of challenges faced.

Mr Bedford advised that it was not the intention to go through each area on a group by group basis. It was anticipated that information provided within the report was helpful and informative. As reporting progresses during the year a more detailed discussion would be generated.

Mr Bedford informed the Committee that once the organisation structure under the Chief Operating Officer had been agreed and implemented the reporting group structure would also change. It was noted the IJB positions were also reported, however, at this stage did not reflect the internal cross charging for hosted services between each of the 3 bodies. This was incorporated into the July 2016 statements and was based on an agreed split.

It was noted each of the IJBs held governance meetings prior to the end of June 2016 with each noting the risks around delivery of the devolved GP Prescribing budget, challenges around the Forensic Medical Service and the Locum spend position in both GAP and Learning Disability, recognising the recruitment difficulties identified. The recruitment difficulties were not expected to be resolved in the short term.

Mr Bedford advised Efficiency Savings were detailed within Table 19 of the report and reflected an unbalanced LDP of £11.65m. The shortfalls were principally against Workforce, Operational Savings and IJBs. It was noted the IJB governance meetings considered progress against delegated efficiency savings and work was ongoing with the IJBs to monitor their plans in line with the Transformation Programme. Information received from the eRostering and Safecare Systems had identified opportunities to manage time out more effectively which would directly reduce supplementary costs in coming months. The shortfall against prescribing was a component and had already been identified as had the challenges within the IJBs on supplementary costs.

Mr Bedford advised the assessment of what could be delivered in 2016/17 would again be assessed as part of the forecast outturn that would begin to firm up now that the first quarter trends were known. It was noted driving efficiency would minimise waste.

Mr Bedford re-iterated that the Board Contingency had not been released at this stage. The July 2016 position reflected an overspend position of c£5.5m, deteriorated by £1m. This was in relation to £3.9m unbalanced LDP and £1.6 in cost pressures.

Mr Cross noted the new style of reporting reflected the overspend position of c£4.5m as at June 2016, the report identified where money was being spent, in particular, Section 3.7 of the report which detailed the spends of each area. Mr Cross highlighted that if the Board Contingency had been released the gap would be reduced, however, this was there as a backup and should be held off as long as possible.

Mr Cross noted the financial challenges faced around pay, prescribing and the savings targets delegated to the IJBs. Mr Cross highlighted NHS Tayside was in unchartered territory in respect of the challenges faced with the delivery of the savings targets by the IJBs and the requirement for NHS Tayside and the IJBs to support each other through close working.

Mrs Golden welcomed the new style of reporting, however, raised queries regarding Table 1 and the progress of the IJBs in comparison to the CHPs, Table 6 prescribing issues, welcomed the reduction in Secondary Care prescribing costs, however, queried how this would be managed in the future and Table 19, the required savings of £1.25m, which highlighted areas that were significantly underperforming, querying what action was planned.

Mr Bedford advised that there were complexities in respect of the IJBs in that the budget was not the same as the CHPs. There were different elements, however, they all reflected GP prescribing costs, Perth and Kinross continued to face challenges around Mental Health and Support Staff and there was a continuation in the spend pattern in Angus. A high level of challenges had been identified within non hosted services and the Forensic Medical Services. Prescribing costs continued to be a challenge for all IJBs, however, the Secondary Care budget recognised the introduction of new drugs.. The introduction of Bio-similars was being actively taken forward in Tayside and would have a significant benefit on costs.

In relation to the efficiency savings required and action required in respect of areas not meeting savings targets, Mr Bedford advised that an encouraging report had been submitted to the TPB following work undertaken by Mrs Eileen McKenna, Associate Nurse Director, highlighting the progress made with the eRostering System and although there were inconsistencies with the management of time out periods better information was being received through the Safecare System.

Mr Marshall was concerned that information in relation to workstreams was not filtering through to the Committee and highlighted the importance of sharing information. Mr Cross advised the Committee that details of work undertaken through the workstreams was initially reported to the TPB followed by Tayside NHS Board.

10:45 Dr Baxter Millar arrived

Mr Gall recognised the report provided clarity and noted future reports would include more detail. This was confirmed by Mr Bedford.

Cllr Doogan agreed the new style of reporting was clearer and noted the substantial financial challenges, however, did not feel the report highlighted this level of concern.

Cllr Doogan requested the recommendation be amended to remove the reference “wherever practical”, queried the inclusion of the month of April in Table 4 and not within any other charts throughout the report and requested more information in respect of risks associated to IJBs not meeting targets.

Mr Bedford advised that in line with the reporting timelines the April position would not normally be reported, however was included in table 4, to ensure Members were receiving the most up to date information. The Committee noted that it was anticipated the IJBs would invoke the risk sharing agreement and agreed the recommendations within the report would be amended to read “The Committee was requested to note the current position and support the actions being taken by Management to contain spend”.

Mr Gall highlighted that guidance received was clear that Tayside NHS Board delegated saving targets to the IJBs along with the mechanisms to achieve targets. Mr Cross advised that targets had not been met prior to the introduction of the IJBs and agreed moving forward there was the need for close working with the IJBs.

The Committee noted that the TPB and workstreams review the spend against resources within the current operation model and the Workforce Plan and recognised the importance of the utilisation of workforce and benchmarking tools.

Mr Bedford advised the Committee there were a number of challenges in the reporting of pay including weekly paid staff, 4 and 5 week months, rostering with enhancements being paid in arrears and Public Holidays.

Mr Cross concluded that there was agreement that the new style of reporting was preferred and the possibility of inviting area representatives to future meetings to discuss issues may be beneficial. The Committee sought assurance from Tayside NHS Board and the TPB around workforce and actions taken in the delivery of savings and noted the work of the Performance Management Group.

The Committee

- **Requested the recommendation within the report be amended to read “The Committee was requested to note the current position and support the actions being taken by Management to contain spend**
- **Noted the report**

6.3 Reporting Requirement – Code of Corporate Governance (FRC42/2016)

Mr Bedford advised the purpose of the report was to advise the Committee of the exercise of delegated authority, waiver of competitive tendering and the number of awards of contracts in excess of £150k.

Mr Bedford informed the Committee that each of the awards of contracts were in relation to the current Capital Programme, which had identified funding sources, and had the lowest cost tenders received. It was noted there was also a number of Single Tender Approvals and all recognised the specific circumstances noted with regards to the Single Tender status.

Mr Bedford spoke in relation to the Beds for Murray Royal Hospital. This recognised the implications of the assessment of the environmental conditions and was the only bed which met the technical/clinical requirements of the patient group.

It was noted that there was a Board contingency of £3m, of which £1.3m was set aside for environmental aspects funding the purchase of one bed.

Mr Cross queried why only one bed had been purchased. It was noted that this issue had been discussed at the Clinical and Care Governance Committee where concerns were raised regarding lengthy timescales and the process of ensuring beds were fit for purpose.

It was agreed care should be taken with Single Tender work to ensure timeous progress.

The Committee

- **Noted the content of the report**

6.4 Property Asset Management Strategy Update 2016 (FRC40/2016)

Mr Anderson advised the Committee the purpose of the report was to ask the Committee to note the Property Asset Management Strategy (PAMS) Update. This was in accordance with CEL 35 (2010), A Policy for Property and Asset Management in NHS Scotland.

The Committee noted that previously the PAMS would be reviewed and approved on an annual basis. The Scottish Government Health Finance and Infrastructure Directorate (SGHFID) advised all NHS Boards in 2015 that reporting requirements had changed and the PAMS was now required to be submitted for review and approval every 2 years with an interim update provided each subsequent year.

It was recognised that the PAMS must be led by NHS Tayside's Clinical Services Strategic Framework which was supported by specific Clinical Services Strategies. These strategies recognised a significant shift around IM&T Assets, Property and Backlog Maintenance.

It was noted that following requirements set by SGHFID, NHS Tayside had adopted the revised Statutory Compliance Audit Reporting Tool (SCART) for all effected 53 sites. It was noted NHS Tayside's overall compliance across the 53 sites was 48.14% for 2015/16. The PAMS Update Report 2016 highlighted the key elements to be addressed to comply with requirements set by SGHFID.

Mr Anderson informed the Committee the NHS Tayside Capital Forecast 2016/17 – 2020/21, attached at Appendix D of the report, had been developed taking cognisance of the identified clinical strategies and risks.

Mr Anderson advised the Committee that NHS Tayside faced significant challenges in reducing backlog maintenance due to the size and ageing property portfolio. A breakdown of the backlog expenditure was included within the appendices of the report. It was noted there had been a significant increase in the backlog expenditure, rising from c£60m to c£100m, primarily related to infrastructure and work was ongoing with Scottish Government to address this.

The Committee noted that many of properties within NHS Tayside were ageing and there were challenges faced in maintaining these builds and ensuring they were fit for purpose. Mr Anderson advised there was a legacy of critical investment required and any monies received by the Property Department through the capital allocation would be allocated to address Statutory Compliance Infrastructure.

Dr Cowie raised concerns regarding the 70% of very high risk backlog maintenance within the community, noting investment could not be seen going into the community and suggested further information regarding high risk areas would be helpful. Mr Anderson advised there were complexities within these areas with the requirement for risk assessments to be carried out. It was noted investment of monies would be allocated to those risk assessed the highest and were aligned with Strategic and Clinical Strategies.

Dr Cross advised there had been a recommendation from the Chief Internal Auditor that the Committee allocated more time and scrutiny reviewing property, in particular those areas of high risk, noting that there were some areas this Committee could not make decisions on. It was noted this would be built into the work plan and requested a further updated to the Committee at its meeting in November 2016 detailing key issues, high risk areas and proposed plans.

MA

Mr Gall noted that service drives the Property Strategy with Clinical Strategies feeding into the PAMS. It was noted assurance was required that the PAMS was fully supported.

Cllr Doogan noted that there were a number of properties that were older than the Ninewells site and suggested these properties should be identified and disposed of with investments being allocated elsewhere.

The Committee

- **Noted the content of the strategy update**
- **Noted the Property and Asset Management Strategy Update**
- **Noted the changes to the PAMS since the submission of the strategy to Scottish Government in 2015**
- **Noted the importance of the PAMS linking in with the Clinical Strategies**
- **Noted the Work Plan would be updated to include regular Property updates**
- **Noted an update to the November Committee meeting detailing key issues, high risk areas and proposed plans**

7. ASSURANCE – Strategic Risks Aligned to the Finance and Resources Committee

7.1 Assurance Report on Strategic Financial Plan Risk (FRC49/2016)

Mr Bedford advised this report had been prepared in line with the agreed reporting arrangements to Committees in support of the Board Assurance Framework in relation to the Strategic Risks on the register.

It was noted the current risk expose was 5x5 (very high) and current controls were detailed within the DATIX report. The magnitude of the risk presented was recognised and the report reflected the unbalanced Local Delivery Plan (LDP) submitted to Scottish Government in May 2016.

The Committee was advised the scale of the programme being accelerated, in order to return NHS Tayside in the medium term to a financially balanced position, was recognised. It was noted the progression of individual workstreams was integral to the recovery required as was work being advanced nationally, however, the need to ensure no double counting was paramount.

The Committee

- **Noted the content of the report**

11:30 Ms Margaret Dunning arrived

7.2 Assurance Report on Reduction in Capital Risk (FRC45/2016)

Mr Bedford advised the Committee this report was in similar vein to the Strategic Financial Plan Risk Report and current controls were detailed within the DATIX report. It was noted the current risk exposure had reduced in August 2016 to 4x4 (high) and there was an awareness of the current constraints nationally on Capital Resources.

The Committee was advised that the Clinical Strategy would inform the future direction of both asset release and asset investment. It was noted the Capital Scrutiny Group (CSG) remained a key forum for considering priorities and the consideration of Initial Agreements and Business Cases to be submitted to the national Capital Investment Group.

The Committee

- **Noted the content of the report**

7.3 Assurance Report on Information Governance Risk (FRC37/2016)

Ms Dunning presented the report to the Committee for information. It was noted the current risk exposure was 4x3 (high) and was a reflection of the ongoing work to comply with DL (2015) 17 Information Governance and Security Improvement Measures 2015 – 2017. This would continue to be monitored through the Information Governance Committee.

The Committee noted current controls were detailed within the DATIX report and the System Access and Information Security Policies were items on the Agenda for this meeting.

Mr Cross queried the progression of the Improvement Plan. Ms Dunning advised there had been set backs as a result of the cancellation of the December 2015 meeting and the retiral of the Information Governance Manager, however, NHS Tayside was well placed and the organisation was not exposed.

Ms Dunning advised of the intention to provide a more specific update to the next Committee meeting.

The Committee

- **Noted the content of the report**

9. ITEMS FOR INFORMATION

9.1 Record of Attendance

The Committee

- **Noted the Attendance Record**

10. POLICIES

10.1 System Access Policy

The Committee was asked to approve the changes to appendix 4, page 15 of the NHS Tayside System Access Policy.

The Committee

- **Approved the changes to appendix 4, page 15 of the NHS Tayside System Access Policy**

10.2 Information Security Policy

Ms Dunning advised the Committee was asked to adopt the Information Security Policy.

It was noted there was a requirement for all NHS Scotland Boards to comply with DL (2015) 17 Information Governance and Security Improvement Measures 2015 – 2017, which included the new NHS Scotland Information Security Policy Framework (ISPF). Ms Dunning advised the Information Security Policy was previously included within the NHS Tayside Information Governance Policy, however, in order to comply with the requirements of the ISPF a separate Information Security Policy had been produced.

Ms Dunning acknowledged NHS Tayside would not be complacent and noted the Improvement Plan would ensure key issues were addressed, such as the requirement of a designated Security Manager.

The Committee

- **Adopted the Information Security Policy**

DATE OF NEXT MEETING

The next meeting of the Finance and Resources Committee will take place on Thursday 17 November 2016 at 9:30am in Committee Room 1, Level 10, Ninewells Hospital, Dundee

Subject to any amendments recorded in the Minute of the subsequent meeting of the Committee, the foregoing Minute is a correct record of the business proceedings of the meeting of Tayside NHS Board Finance and Resources Committee held on 18 August 2016, and approved by the Committee at its meeting held on 17 November 2016.

.....……....	.....
CHAIR	**DATE**

Minute NHS Tayside

TAYSIDE NHS BOARD
AUDIT COMMITTEE - OPEN BUSINESS

Minute of the meeting of Tayside NHS Board Audit Committee held at 9.30 a.m. on **Thursday 1 September 2016** in the Board Room, Conference Suite, King's Cross, Dundee

Present:
Mr D Cross, OBE, Non Executive Member, Tayside NHS Board
Councillor D Doogan, Non Executive Member, Tayside NHS Board
Ms L Dunion, Non Executive Member, Tayside NHS Board
Mrs J Golden, Non Executive Member, Tayside NHS Board
Mr S Hay, Non Executive member, Tayside NHS Board (Chair)
Mr M Hussain, Non Executive Member, Tayside NHS Board
Councillor G Middleton, Non Executive Member, Tayside NHS Board

Chair, Chief Executives and Senior Officers
Mr L Bedford, Director of Finance, NHS Tayside
Prof J Connell, Chair, Tayside NHS Board
Mr R MacKinnon, Associate Director of Finance - Financial Services & Governance/FLO, NHS Tayside

External Auditors
Mr B Crosbie, Senior Audit Manager, Audit Scotland

Internal Audit – FTF Audit and Management Services
Mr B Hudson, Regional Audit Manager, FTF Audit and Management Services
Mrs J Lyall, Acting Regional Audit Manager, FTF Audit and Management Services

Other Attendees
Mr D Colley, Finance Governance Accountant, NHS Tayside
Ms M Dunning, Board Secretary, NHS Tayside
Mrs F Gibson, Head of Financial Services, NHS Tayside
Mrs L Green, Committee Support Officer, NHS Tayside
Miss J Haskett, General Manager – Primary Care Services, NHS Tayside (for items 10 &16.1)
Miss D Howey, Head of Committee Administration, NHS Tayside
Mrs L Lyall, Capital Finance Manager, NHS Tayside (for item 9)

Apologies
Mr G Doherty, Director of Human Resources, NHS Tayside
Mr T Gaskin, Chief Internal Auditor, FTF Audit and Management Services
Ms L McLay, Chief Executive, NHS Tayside

Mr S Hay in the Chair

1. WELCOME **ACTION**

Mr Hay welcomed all to the meeting in particular Mr Bruce Crosbie, Senior Audit Manager, Audit Scotland who were now the external auditors for NHS Tayside.

It was noted that Mr Lindsay Bedford was now the Lead Officer for the Audit Committee following the re-organisation of the Chief Executives management structures.

Mr Hay asked Mr Bedford to update the Committee regarding the reporting arrangements for the Open Minute of the Audit Committee 21 June 2016 meeting.

Mr Bedford informed the Committee that under the terms of the Public Finance and Accountability (Scotland) Act 2000, Tayside NHS Board was not permitted to allow details of discussions regarding the Accounts to be publicly available prior to being formally laid before Parliament.

It was noted that Item 4.1 on the Agenda was a summary of the Open Minute of the Audit Committee of 21 June 2016 and excluded discussions relating to the Annual Accounts for the year to 31 March 2016 and PricewaterhouseCoopers Annual Report on the 2015/16 Audit to the

Board and the Auditor General for Scotland. The full Open Minute of the Audit Committee of 21 June 2016 was to be taken in reserved business as Item 14.1 on the Agenda. The Committee noted that the full Open Minute would be made publicly available following being laid before Parliament and would be reported in open business at the December 2016 Committee meeting.

2. APOLOGIES

The apologies were noted as above.

3. DECLARATION OF INTERESTS

There were no declarations of interests.

4. MINUTE OF PREVIOUS MEETING

4.1 **Minute of the Audit Committee Minute – 24 March 2016**

The Audit Committee Minute of the meeting held on 21 June 2016 was approved on the motion of Mr Doug Cross and seconded by Mrs Judith Golden.

4.2 Action Points Update

Mr Bedford spoke to the Action Points Update.

Recording Equipment – It was noted the last Workforce and Governance Forum was postponed due to quoracy and the matter around the use of recording equipment at Committee meetings would be discussed at its next meeting.

Mr Hay advised that as this matter was unresolved this meeting would not be recorded.

External Review of all Mental Health Sites – It was noted an update regarding the external review relating to original build specifications for all Mental Health sites would be reported to the Strategic Risk Management Group (SRMG) followed by an update to the Audit Committee. Mr Bedford advised the Committee that an external review of Hospital Build Programme and Governance of the Programme for Murray Royal Hospital had been undertaken by Health Facilities Scotland and would be included in the update to the Committee at its December 2016 meeting.

Mrs Dunion raised concerns regarding the timing of reporting to the Committee as this review was likely to be included within the Health and Safety report. Mrs Dunion queried when the Health and Safety report was expected to be issued and whether the Committee should be updated prior to the Health and Safety report being issued. Mr Bedford agreed to discuss reporting arrangements with Mr Mark Anderson, Head of Property. **LB**

It was noted the next SRMG meeting was November 2016.

Progress on Internal Audit Report T21/14 Medical Instrumentation and Devices – It was noted an update was included within the Audit Follow Up - Full Audit Cycle Update report, which was an agenda item for this meeting.

Mr Bedford advised the Committee the Head of Instrumentation post had been filled and the Committee would be updated regarding the appointment at its December 2016 meeting.

Annual Report of the Strategic Risk Management Group 2015-16 – It was noted Mr Hay had been in consultation with Ms Lesley McLay regarding the issue of risk managers attendance at SRMG meetings.

Adverse Events Management Policy – It was noted this item was deferred to September 2017 to allow for significant areas of work to emerge and be given the appropriate time to conclude prior to being incorporated into the revised version of this policy.

4.3 Work Plan 2016/17

Mr Bedford advised the Committee that a full review of the work plan would be undertaken to ensure accuracy. **LB**

The Committee

- **Noted the Work Plan 2016/17**
- **Noted a full review to be undertaken**

4.4 Matters Arising

There were no matters arising.

5. AUDIT FOLLOW UP

5.1 Audit Follow Up (AFU) – Full Cycle Update Report (AUDIT68/2016)

Mr Bedford advised the Committee that the report provided a progress update on action taken, up to 30 June 2016, relating to recommendations made in Internal and External Audit reports and looked at high risk action points and Audits with a D status.

Mr Bedford made reference to the self explanatory Appendices contained within the report which included comments from Responsible Officers on the status of the action.

Mr Bedford provided the Committee with an update on the following actions with a D status:

T21/14 Medical Equipment and Devices – It was noted three action points remained outstanding with progress expected following the appointment to the post of Head of Instrumentation, with the post holder due to commence late September 2016. An update would be provided to the Committee at its meeting in December 2016.

T17/15 Health of the Population – It was noted one minor action point remained outstanding, as reported to the Committee in May 2016, and was dependant on a national initiative which was due for completion this Autumn.

T23A/15 Enhancements During Leave – It was noted there was one action point outstanding which required approval by the Staff Governance Committee.

T06/17 Annual Report of Internal Control Framework – It was noted this was presented to the June 2016 Committee meeting with one action point covering the incomplete recommendations from the Interim Report, presented to Committee February 2016, and was included within Item 5.2 on the Agenda for this meeting.

T36C/16 Departmental Review of Outpatients - Mr Hay raised concerns regarding the delay of the implementation of Gynaecology job plans. Mr Colley advised that further information was expected from Mrs Dawn Sturrock, Business Change Lead by the end of the month, however, was prioritised as of low importance and included within the report due to the delay.

The Committee

- **Noted the findings for this full cycle to June 2016**

5.2 Interim Evaluation of Internal Control Framework 2015/16 Audit Report No. T08/16 (AUDIT69/2016)

Mr Bedford advised that the purpose of this report was to update the Committee regarding the actions which arose as a result of the Interim Evaluation of Internal Control Framework presented to the Committee at its meeting in February 2016. It was noted this report had a broad range of assessments and was considered in detail by both the Audit Committee and, on their recommendation, Tayside NHS Board. Tayside NHS Board and Senior Officers had recognised the significance of the report and the actions/recommendations which arose from it.

It was noted a further update would be given at the December 2016 Committee meeting, at which time the 2015/16 Interim Review was due, and close working with Internal Audit would continue. LB

Mr Bedford advised the Committee that a number of actions had been completed with others in the process of being actioned. Mr Bedford highlighted there were a number of significant activities taking place through the governance of the Transformation Programme Board (TPB), which were reported through Tayside NHS Board. There was recognition of the Audit Scotland Checklist for Non Executive Members and there was the intention as part of the desktop session, scheduled for 22 September 2016, to consider Non Executive Members assessed level

of confidence in affirming or otherwise to each of the questions posed. It was expected this would result in a number of actions which would be reported to the December 2016 Committee meeting.

Mr Bedford noted that the Chief Executive's revised corporate structure was now in place and as a result support structures were now, for the corporate areas, well developed and looking to progress with a level of urgency. This included the Finance Directorate.

The Committee noted that Mr Bedford and the Chairs of the Audit and Finance and Resources Committees would present a paper to the November 2016 Finance and Resources Committee meeting for consideration following a review of the remit, reporting arrangements and operation of the Finance and Resources Committee. Reporting arrangements to the Finance and Resources Committee would continue to evolve with the ambition of it being informative, intelligible and digestible. LB

The desktop session for Non Executive Members, scheduled for 22 September 2016, would focus on the actions articulated in the Interim Review, in particular ones where finance was a link.

It was noted a number of actions would be progressed through the Staff Governance Committee. There were a number of actions which remained ongoing with regards to Community Planning and Single Outcome Agreements (SOAs). An update regarding these actions would be included in the update to the December 2016 Committee meeting.

Mr Cross advised, from a Finance and Resources Committee point of view, that the audit report had been taken seriously and he had met with Mr Bedford on many occasions to discuss the format of reports and reports being more accessible. It was noted the Corporate Financial Report had been presented at the last Finance and Resources Committee in a different format and had been well received. There was a suggestion to invite representatives from department areas of significance to the Committee to future meetings to discuss any issues gain an understanding of department pressures. Mr Cross noted the need for close working with the TPB.

The Committee queried what feedback had been received from Internal Audit in relation to recruitment and restructuring, if there were any areas of particular concern and sought clarity around the progress of the restructuring of the Finance Department. Mr Bedford advised that corporate areas were well developed and proposals on direct reports, which had been discussed at many Directors Forums, gave prominence to governance and assurance and discussions had been held with Staff Side around how vacancies would be filled.

Mr Bedford advised there had been some challenges in recruiting, with a poor response to a number of posts going out to advert. It was noted all public sector bodies were finding challenges in recruitment and NHS Tayside were taking a more robust approach with vacancies being advertised on the external NHS Tayside website, the Finance Department micro site and the use of external recruitment agencies, for example LinkedIn. Mr Bedford advised he was in regular contact with Internal Audit and noted the Chief Internal Auditor was assured with the measures being undertaken.

The Committee

- **Noted the current position**

6 FTF/INTERNAL AUDIT

6.1 FTF Audit and Management Services Internal Audit Progress Report (AUDIT67/2016)

Mr Hudson advised the Committee the report provided an update around the 2015/16 and 2016/17 Internal Audit plans.

It was noted the report highlighted areas where audit work had been completed, areas where draft reports had been issued and areas of work in progress. Mr Hudson advised there had been some delays, explanations of which were given within footnotes contained within the report.

It was noted a summary of each report was included as Appendix 1 of the report.

Mr Hussain requested assurance regarding the number of audits graded as being N/A. Mrs Lyall advised that the majority of these were yearend reports which routinely do not have an overall grade as each governance area was graded separately. The exception was eHealth Strategy, Planning and Governance which was audited at the request of management with the intention to aid decision making by NHS Tayside Clinical and eHealth Management and Tayside Health fund where individual areas had been graded separately. It was noted the full Tayside Health Fund Audit Report was available on the Members Library page on Staffnet.

Mr Hay queried financial awareness of staff in relation to Departmental Reviews. Mr Hudson advised this could be built in to audit work and Internal Audit would liaise with Mr Bedford regarding this.

Following a query from Mr Hay in relation to exit strategies being in place for eHealth, Mrs Lyall advised the Committee that the eHealth report contained an action point regarding this and this would be addressed in the standard Audit Follow Up process.

Mrs Golden commended the A- grade for the department review of Ward 11, Ninewells Hospital.

The Committee

- **Noted the progress on the 2015/16 and 2016/17 Internal Audit plans**

7. UPDATES TO THE NHS TAYSIDE CODE OF CORPORATE GOVENANCEE (AUDIT61/2016)

Ms Dunning advised that the Committee was asked to scrutinise the proposed changes to the Code of Corporate Governance to incorporate the partnership between the Universities Strategic Liaison Committee (USLC) and the Academic Health Science Partnership (AHSP) and to recommend approval of the updates by Tayside NHS Board.

It was noted Appendix 1 highlighted tracked changes to Section A, Committees, 8. Purpose and Remits, Universities Strategic Liaison Committee and the Code of Corporate Governance would be updated following approval by Tayside NHS Board.

The Committee

- **Scrutinised the updates to the Code of Corporate Governance and recommended its approval by Tayside NHS Board at its meeting on 27 October 2016**

8. BEST VALUE FRAMEWORK 2016/17 (AUDIT70/2016)

Ms Dunning advised the Best Value Framework would normally be submitted to Tayside NHS Board at its June and August meetings followed by submission to Standing Committees to allow the delegated characteristics to be incorporated into work plans. It was noted Internal Audit had recently produced an Internal Audit Report on Best Value. The Framework had been updated to take account of the findings from this report and previous comments from Board Members.

Ms Dunning advised the Framework now gave an explanation of the status of the outcome and advised arrangements would be made with all Standing Committees for the discussion of the Best Value Framework to ensure the Lead Officer, Chairs and Vice Chairs were clear of the arrangements and would ensure that these would be reflected in individual Committee work plans.

Mr Hay thanked Ms Dunning for the report and noted he found the template to be helpful and significantly clearer than previous versions.

Mr Cross noted a number of actions which were attributed to the Transformation Programme Board, and queried whether some of these should be the responsibility of the Standing Committees. Ms Dunning again confirmed that it was the intention to hold meetings with the Lead Officers, Chairs and Vice Chairs of the Standing Committees to discuss the Best Value Framework and the expectations that this placed on the Standing Committees and their work plans.

Mrs Dunion agreed there was an improvement in the format of the Framework, however, was concerned that the measure/expected outcome column should focus more on the impact/specific measures.

Mr Hay suggested further work was required to "tighten" up the Framework, highlighting, this was the responsibility of the Standing Committees and would be discussed at the individual meetings.

The Committee

- **Scrutinised the Best Value Framework 2016/17, attached as Appendix 1, prior to submission to Tayside NHS Board for approval**

9. PROPERTY TRANSACTION MANAGEMENT (AUDIT66/2016)

Mrs Louise Lyall was in attendance for the report and informed the Committee that the purpose of the report was to advise of the Internal Audit of the property transactions completed in 2015/16 and to provide assurance that the required procedures had been followed.

The Committee was asked to note the recommendations set out within the report.

Mrs Lyall advised the Committee that there were three property transactions during 2015/16, previously reported to the Committee at its May 2016 meeting and there was a request for FTF Internal Audit to review the transaction to ensure that the requirements of the Property Transactions Handbook (PTH) had been followed.

It was noted that there was an error in the details of the split of sale proceeds between NHS Tayside and the Scottish Executive Environmental and Rural Affairs Department (SEERAD) in the Post Transaction Certificate for the surplus land at the former Royal Dundee Liff Hospital site, presented to the Committee in May 2016. The certificate stated that the sale of proceeds would be shared on a 50:50 basis, however, NHS Tayside was entitled to 52% of the total sale proceeds. Mrs Lyall advised that following discussion between management, Internal Audit and SEERAD it was agreed that a revised certificate was not required as all parties were aware of the required split for sale proceeds.

It was noted a clean property transactions return for 2015/16 would be submitted to the Scottish Health and Social Care Directorate (SGHSCD) by the deadline of 30 October 2016.

Mr Cross felt the audit report reflected a department which was stretched and raised concerns regarding posts which remained unfilled and issues around record keeping and duplication. He noted, however, there was some reassurance in relation to posts that had been filled and suggested a refresh of procedures was required.

10:15 Miss Jane Haskett arrived.

Mr Bedford advised that the department had welcomed the appointment of Mr Mark Valentine to the post of Property Asset Manager and two Asset Officers and gave assurance issues regarding record keeping would be investigated. It was noted Members expected to see an improvement in record keeping within the 2016/17 Post Transaction Monitoring report.

The Committee

- **Noted the requirements of the PTH had been complied with**
- **Noted the Internal Audit report was attached at Appendix 1**
- **Noted arrangements were in place to issue Tayside NHS Board's Annual Property Transactions Return to the SGHSCD by the deadline of 30 October 2016, and the return would be submitted with no significant issues identified**

10. PAYMENT VERIFICATION: FAMILY HEALTH SERVICE (FHS) CONTRACTORS Payment Verification – Annual Process Update (AUDIT62/2016)

Miss Jane Haskett was in attendance for this report.

Miss Haskett advised that following approval by the Committee in May 2016 to amend the reporting arrangements of Payment Verification (PV) this report was an annual scene setting report and highlighted the PV mechanisms. It was noted this was one of two papers to be presented at this meeting.

Miss Haskett advised that Committee that the purpose of the report was to inform the Committee of updates to the guidance on the National PV procedures and arrangements for PV for 2016/17 for each of the FHS Contractors, i.e. General Dental, Ophthalmic, Pharmaceutical and Medical Services as highlighted in Appendix 1 DL (2016) 11 and the assurances in respect of the discharge of financial governance to ensure best practice, fairness and the proper use of public funds.

It was noted that a new Scottish GMS Contract was being developed with the implementation of an initial framework from April 2017 resulting in the scope of PV for Medical Services being significantly reduced form 2017/18. Miss Haskett advised that confirmation of PV processes from April 2017 onwards was awaited and an additional report would be presented to the Committee, out with the annual report, when there were clear arrangements in place.

Mr Hay advised Miss Haskett she would be notified of any feedback from Members regarding this form of reporting.

The Committee

- **Noted the content of the report.**

11. PAPERS/MINUTES FOR INFORMATION

11.1 Corporate Governance Review Group Action Note – 19 May 2016 (unapproved)

The unapproved Governance Review Group Minute of 19 May 2016 was presented to the Committee for information.

The Committee

- **Noted the Corporate Governance Review Group Action Note – 19 May 2016**

11.2 Attendance Record

The Committee

- **Noted the Attendance Record**

11.3 Audit Scotland – External Auditors

Mr Bedford advised the Committee that the tenure with PricewaterhouseCoopers had ended at the end of 2015/16 and Audit Scotland would now be working with NHS Tayside for a period of 5 years.

Mr Bedford introduced Mr Bruce Crosbie, Senior Audit Manager for Audit Scotland and advised Dundee City Council and Dundee Integration Board were also within Mr Crosbie's remit.

Mr Crosbie informed the Committee that he was part of a strong team reporting to Ms Fiona Mitchell-Knight, Assistant Director, Audit Services and looked forward to working with NHS Tayside. He advised that the Audit Scotland team had some background working within and NHS environment, working previously with NHS Fife, along with FTF Internal Audit and had developed a good relationship with Internal Audit.

The Committee

- **Noted the verbal update**

11.4 Audit Scotland – Reports

The Agenda provided links to the following Audit Scotland Reports:

- Code of Audit Practice
- Strategy and Annual Action Plan
- Engagement Strategy
- Corporate Plan 2016/17 Update
- Audit Scotland Annual Report 2015/16
- Transparency and Quality
- Annual report and Accounts 2015/16
- Technical Bulletin 2016/2

The Committee

- **Noted the Audit Scotland Reports**

12. DATE OF NEXT MEETING

The next meeting of the Audit Committee will take place on Thursday 15 December 2016 at 9:30am in the Board Room, Conference Suite, Kings Cross.

Subject to any amendments recorded in the Minute of the subsequent meeting of the Committee, the foregoing Minute is a correct record of the business proceedings of the meeting of Tayside NHS Board Audit Committee held on 1 September, and approved by the Committee at its meeting held on 15 December 2016.

.....……..	.....
CHAIR	**DATE**